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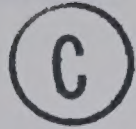
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THE UNIVERSITY OF ALBERTA
THE GRIEF EXPERIENCE IN THE FIRST
YEAR OF BEREAVEMENT

by



STANLEY LESLIE ERRETT

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTER OF EDUCATION

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

SPRING, 1975

THE UNIVERSITY OF ALBERTA
FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "The Grief Experience in the First Year of Bereavement" submitted by Stanley Leslie Errett in partial fulfilment of the requirements for the degree of Master of Education.

ABSTRACT

It is not uncommon in the North American culture for the grief sufferer to develop pathological symptoms. There is a need to better understand the nature and the process of the grief experience for the purpose of enabling the bereaved to cope more effectively. In the course of his pastoral duties the author conducted case studies of the immediate survivors in five bereaved families over a one-year period following a death. Four of these were completed, three cases involving the loss of a husband and one case the loss of a child. Supplementary material was added from the observation of fourteen other families with whom the author had worked. The approach was to continue the routine clergy-parishioner relationship so that the mourners were visited at regular intervals for a year following the loss. Their reported experience and observations of their reactions were recorded verbatim at the time of the pastoral call. At the conclusion of the first year this data was analyzed under the categories of immediate reaction (1-30 days), early reaction (2-6 months), and late reaction (7-12 months). The dominant themes in the mourners' experience were distilled from the reactions. Based on these experiential themes it was possible to

construct a profile of grief. Three distinct phases of "grief-work" emerged and offered a probable profile of the grief experience: an orientation to the loss, a growing recognition of the loss, and an attempt to compensate for the loss.

The case study approach appears to be the best method for understanding the grief experience, even though it involves the problem of generalizability. Because of the nature of this study generalizations can best be made in the case of the death of a husband.

ACKNOWLEDGMENT

I wish to express my sincere thanks to the members of my committee, Dr. L. Eberlein, supervisor, Dr. W. Hague, and Dr. J. Guild.

I am also indebted to the survivors of loss who allowed me to share in their experience.

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CHAPTER I

INTRODUCTION

Statement of the Problem

Most of the literature on the subject of grief has been of a philosophical, theological, spiritual and ritualistic nature. It has dealt with the metaphysical question of reality, of life beyond death, the nature of God, the problem of human suffering, Biblical references to an after-life and the spiritual means of comfort for the bereaved. Little of an investigative nature has been done to understand the grief process or the varieties of experiences that are possible for the recently bereaved.

Thomas Eliot (Fulton, 1965) called for the first objective analysis and study of grief in 1930. This marked the beginning of the comparative studies. At the time of writing we have theories of grief developed by Sigmund Freud (1917/1949), Anna Freud (1943/1960) and Lindemann (1944). The gathering of research articles on grief theory by Fulton and Kutchner (1969) has added significantly to the work of the aforementioned pioneers. Abnormal grief has been identified and investigated by Freud and Lindemann. Many researchers have begun to see grief as a process and attempted to identify the stages through which it moves.

For this we are indebted to Oates (1954), Westberg (1961), Hodge (1972), and Parkes (1973) amongst others. There is evidence that the process can begin prior to the death of a family member according to Knight and Herter (Kutchner, 1969) and that the length of time for preparing for the loss can be crucial to the subsequent adjustment of the survivor (Parkes, 1973). Although there is no substantial evidence, a recent survey indicates that the medical profession is significantly divided in its philosophy of the use of drugs in treating the bereaved patient. (See Appendix B.)

Are there themes common to all, universal experiences (emotional, social, physical, spiritual) or parts thereof which characterize the existence of the bereaved in the first year following the death of a family member? Are there experiences known to each of the bereaved whether the situation involves a low-grief or high-grief death, the loss of a spouse, a child or a parent? To what extent do the experiences of the bereaved differ from each other? What are some of the possible causes of these differences? The purpose of this study is to explore further the questions posed above and to suggest areas of further enquiry into this little-understood experience of man.

Importance of the Study

In 1972, the last year for which vital statistics are at present available, there were 162,413 reported deaths in Canada (Vital Statistics, 1972, p. 23). Of these, 10,699

occurred in Alberta. Death by accident, poisoning and violence accounted for 16,351 or approximately 10 percent of the total figure. Deaths attributed to diseases of the circulatory system, respiratory system and the presence of neoplasms totalled 123,130. No age was immune: in the 5-9 years age group there were 965 deaths; the 10-14, 963 deaths; the 15-19, 2,440 deaths; and in the 20-24 age group, 2,514 deaths.

The number of Canadian families affected annually is not easy to discover. An estimate of 150,000 would not be unwarranted. Further, the implications for the survivors' job performances in industry, academic achievement in schools, and effective emotional and social functioning in general are beyond the imagination. Does the student who loses a parent perform less effectively academically? Does the experience of personal grief tend to lower the competence of a professional in society? If so, for how long? Is every case so different from every other case that comparisons are of little value?

This study has been attempted to focus more attention by the care-giving professions on the nature of the effects of grief on the survivors. It is hoped that it may add something of value to the development of knowledge and skills by which survivors may adjust more quickly and adequately to a world without the presence of a loved one. One hears such assessments of the bereaved as "He has never recovered from her death," "She has not been the same

since Tom died 12 years ago," or "He has never forgiven himself for not doing more for her before she died." These descriptions and many more similar to them indicate that many people do not cope effectively with what is an inevitable experience for almost everyone (the exceptions being those members who are the first in their families to die).

Procedure Followed

In the six-month period following the decision to investigate further the grief process through the case study method, a number of deaths occurred for which the author was invited to perform the funeral services. These deaths included a child killed by an automobile and three husbands by drowning, cancer, and coronary thrombosis. The aim in each case was to continue a routine follow-up of pastoral care with the hope that four of five cases could be observed sufficiently enough over a one-year period to yield adequate material for the case studies.

Because of job transfers from this city, the lack of interest on the part of the survivors to sustain a continuing relationship with this writer and the low yield of some interviews, four of the possible five cases were finally selected for the purpose of this study. The decision was made to follow the normal routine of seeing the survivor(s) a minimum of once every three months for one year following death, making a total of at least five interviews (including as one interview the numerous contacts

at the time of the funeral). As usual, the writer was available to the survivor at their request so that some of the survivors were seen more than five times. In one case, sixteen interviews with one or more members of a family occurred.

The interviews were conducted on the basis of pastoral calls. The minister-parishioner relationship in these cases is best described as supportive. No attempt was made to conduct extensive therapy. In one case, where therapy was indicated, a referral was made to a counselling-psychologist. Following each interview a verbatim report was made which included pieces of conversation considered to be directly or indirectly related to the survivor's experience of grief. An attempt was made to assess the survivor's experience on the basis of reported activities, perceived inner state, family relationships and other events in their lives deemed to be related to the loss.

At the conclusion of a twelve month period an attempt was made to analyze the verbatim reports and descriptive comments for the purpose of relating them positively or negatively to previous research and to the purpose of this study. Only the material gained through the interviews was used as a basis for inference. The author considers himself in an advantageous position from which to note changes in the survivors' cognitive, affective and behavioural patterns because all cases were known to him

prior to the disruption of their families by death.

In addition to the four case studies, supplementary material on another fourteen cases has been organized, analyzed and incorporated into the body of this study. If the study had been planned to take place over a five-year period, they might have served as full case studies. Unfortunately, the deaths in each of these families occurred before the decision was made to explore the grief experience via the case study method. Because these survivors did receive, and in five cases are still receiving continuous pastoral care, it seemed reasonable that information about them might be valuable to this exploration.

Limitations of the Study

Because of the opportunity it affords for on-the-job observation, the case study method lends itself to the accepted role of the clergyman in the minister-parishioner relationship where the parishioner is suffering from grief. Only an outside observer would be permitted to research the parishioner's experience in the first year following the loss of a family member using more formal methods of enquiry. Even then, experience suggests that only 50 percent of the survivors would accept the approach (Parkes, 1973). Three of the cases of this study involved the loss of a husband. The fourth involved the loss of a child. Each of the adults who died were males, approximately 50 years of age. A wider base for research would have been provided

had at least one of the deceased been a wife.

Some limitation of studying grief by this approach is imposed by a cultural factor, namely, that talk of death is taboo in twentieth century America. Gorer (cited in Feifel, 1959) has commented that death was as unmentionable to Americans in the 1950's as sex was to the Victorians. This may suggest one of the reasons why the study of grief, a universal experience of man, has been until very recently neglected by psychology, the science of human behavior and experience.

It is recognized that information gathered by this approach is fragmentary and that verbatim reports of the interviews represent a sketch rather than a finished portrait of the survivor's experience. It is recognized also that different students of these case histories may arrive at different reconstructions from the same evidence. Having stated these limitations the author is aware that in this particular situation these personal case histories can be studied further and the reconstruction validated through gathering of more evidence. In all probability it will be possible to follow each case through another four years of history.

Definition of Terms

Switzer (1970) suggested that grief is used in two ways in the literature. Firstly, it is referred to as though it were a separate emotion with its own set of unique characteristics. It is not stated precisely how it is

different from other emotions except for the obvious reference to the stimulus of death which triggers it. Secondly, it is used to refer to several emotions which are expressed in the presence of the death of a loved one. This author has observed that the term is used increasingly to refer to the constellation of emotions which arise in response to any loss whether it is the removal of a limb, failure in school, forced unemployment or geographical separation from significant others.

For the purpose of this study bereavement is defined as the actual state of the loss. Grief is the emotional response to bereavement. Loss is that which takes place as a result of the death of a loved one. Switzer (1970) rejects the concept that "grief is an emotional reaction to the death of an emotionally significant person . . . which is distinguishable from other emotions" (p. 179). No convincing case has been made for grief as a single emotion. Rather, "grief refers to an interesting group of identifiable emotions which have been stimulated by the death of a related person" (p. 179). The most significant affective element is anxiety. Other emotions which have been reported in relation to grief are depression, guilt, and hostility. Weiss (1950) saw in grief the element of conflict--conflict between the uncontrollable desire for the loved person and recognition that the person no longer exists, between the inner world of needs and the outer world of reality.

CHAPTER II

SOME RELATED LITERATURE

Introduction to Review

Robert Fulton (1970) reported that in 1930 Thomas Eliot called for the first objective analysis and comparative study of grief. However, the first major study did not take place until Eric Lindemann investigated the reactions of the survivors of the Cocoanut Grove fire in New York City in the 1940's. Anna Freud's wartime study of children separated from their families brought the study of grief into sharper focus (1943/1960).

Systematic study, however, began with the publication of Herman Feifel's book The Meaning of Death in 1959. More material by professional researchers appeared in the five years following this publication than in the previous 100. Fulton speculated that the reasons for this were the change from a religious to a secular society, the transformation from an extended to a nuclear family and the change in time, place and incidence of death. In 1970 he estimated that one percent of the population of the United States would die. Sixty-two percent of these deaths would occur in the 65 years and over group. Sixty-one percent of these would take place outside of the home. Only 5½ percent of

all deaths would occur in the 15 years and under group. This dramatic reversal in the mortality pattern means that it is now 20 years, or one generation, that a family can expect not to have a death occur amongst its immediate members.

Theories of Grief

Sigmund Freud (1917/1949) suggested that at the onset of the grief process the survivors' reality-testing facilities indicate that their libido should withdraw itself from its attachment to the loved object. "Against this demand a struggle arises--it may be universally observed that man never willingly abandons a libido position, not even when a substitute is already beckoning him" (p. 154).

This struggle is so intense that a turning away from reality ensues, the object still clung to through hallucinatory wish-psychosis. Usually reality wins--but not immediately. Bit by bit each single memory and hope which bound the libido to the love object is brought up and hyper-cathected until the libido is detached. When mourning is completed, the ego is free and uninhibited again.

Freud distinguished between grief and melancholia: "In grief the world becomes poor and empty; in melancholia, it is the ego itself" (p. 155). The indications for both are the same involving such symptoms as profoundly painful rejection, loss of interest in activities and loss of the capacity to love. With grief, however, there is an absence

of the loss of self-esteem which invariably accompanies melancholia.

Irion (1954) concurred with Freud's theory of the grief reaction, viz., that normal grief involves the gradual detachment of the libido of the mourner. However, he thought that Freud's theory lent itself only to what might be called positive attachments such as a love relationship. Irion considered that Lindemann (1944) added an essential adjunct to Freud's theory by insisting that the same severity of reaction is found where there is a negative attachment (one characterized by hostility and resentment) to the deceased.

Lindemann (1944/1963) saw the grief process as involving an emancipation of the survivor from the bondage of the deceased and a re-integration of life within the framework of an environment from which the deceased had gone. Freud agreed with Lindemann's theory that the person who went through the grief process would find relief and release from the deceased.

Jackson (1959) believed that the:

emotions of grieving tend to cluster about three main psychological processes: incorporation, substitution and feelings of guilt In incorporation the individual turns his feelings in upon himself and in effect becomes part of the deceased person. (p. 222)

This could range from adopting the attitude of the deceased ("Mother would want me to be brave") to acquiring the symptoms of the illness of the deceased. Substitution referred to developing an emotional attachment to some

person or some thing, e.g., the clothes of the deceased or the cemetery. Such objects are invested with more than normal emotional meaning so that in effect they become part of the deceased. An important part of the process of grief-work is that of withdrawing emotional capital invested in the deceased and reinvesting it in other productive relationships.

Rogers (1963) saw grief as the pain which results from cutting a significant person out of the individual's emotional constellation:

The human organism builds into its emotional constellation not only the parts of its own body, but the objects of its environment including other people. People . . . become an extension of one's own personality. Feeling tone develops around these persons . . . according to their importance in the individual's attempt to meet his own needs. (p. 19)

Other people have meaning to him according to his interpretation of their place in his subjective world. The loss of a rag doll, the one familiar and friendly object, may trigger a grief reaction in a child who lives in a constantly changing world.

Rogers considered the birth trauma as the original grief experience. Subsequently grief extended through various experiences of life, being most severe where the deceased has been built into the survivor's affect system as one of his basic items of identification and security. The deceased not only occupied a large portion of his affect system but also a large part of his fantasy system as well. Dreams are built around a future with the deceased. These

may be just as real as the actual relationship and occupy a larger portion of the survivor's emotional constellation. "Something of great importance to the individual, something that is part of his psychic life has been torn out leaving a great pain--the emotion we call grief" (p. 20).

Rogers believed that the grief process involves physical changes in the functioning of the digestive, circulatory and glandular system of the body. Unresolved grief could permanently damage the body. "An emotion repressed is not thereby disposed of but remains dynamic at the unconscious level . . . many times in disguised form, manifesting itself through physical symptoms or personality changes" (p. 21). Grieving was sometimes characterized by pain which was intense enough to cause one to desire to avoid it. He saw it as being closely tied to goals and values. When the meaning of a situation clarified, the emotional reaction was qualified accordingly. Grief was often accompanied by anger. Love and hate were both involved in a relationship. When this ambivalence had not been handled well, it could become a complicating factor in the grief reaction. Another aspect of grief was the presence of guilt feelings. These were frequently present and often the logical outcome of ambivalent feelings. Hostility at the time of bereavement was likely to create guilt feelings of considerable intensity. Guilt feelings were frequently present when no clearly traceable ambivalent feelings manifested themselves. This happened because guilt

feelings could be based on fantasy as well as on fact.

Lipson (1969) contended that the loss of a love object precipitated a struggle within the psyche between the recognition of the reality of permanent loss and a reluctance to abandon a libido position. He emphasized that denial and ego-splitting was related to normal mourning. He conjectured that ego-splitting was a compromise which acknowledged two realities for the mourner, viz., his highly cathected mental representation of the loved object and an absence of perception of the object. He traced what happened following the splitting of the ego:

The instincts, still attached to the object representative, strive for gratification and repeatedly force the ego into seeking the object and finding it absent. With each observation of this absence that part of the ego which has yet to acknowledge the loss experiences a degree of pain and reacts to the recognition of the loss by the regressive process of introjection. Although the ultimate fate of the object representative may be total incorporation, normally this is the result of a series of partial introjections Concurrent with this series of partial introjections is a parallel series of partial detachments from the introject. This is suggested by a gradual diminution of sadness and the slow renewal of energy that takes place during mourning. (p 274)

Evidences of Normal Grief

Normal grief is used here to refer to grief reactions typical of the North American culture. Grief reactions, funeral rites and customs vary between cultures and often within the same culture. For example, in rural Ontario the body of the deceased is kept in his home for a three-day period prior to burial. The immediate family act as hosts. The community come to pay their respects. Crying, laughter,

social singing, and eating form part of the grieving process. In rural Alberta this custom is not practiced. The bereaved may or may not view the body of the deceased. Because the body is kept in a viewing parlor in the local funeral home the opportunity for tears, laughter, and socializing is not so readily available.

One study (Volkart & Michaels, 1957) explored why some people are more vulnerable to particular situations than are others, viz., differential reactions to bereavement. The authors cited culture as an important factor. Although human death is universal, they found every culture had its own beliefs, ideas, values and practices concerning it. For example, it is generally assumed that the bereaved person will be grief-stricken. The authors found that this was not always so.

In North America the prevailing definition of bereaved persons includes the deceased's parents, siblings, spouse, and children. In-laws, cousins, aunts and uncles are included only by virtue of a special relationship. Ordinarily, they are not regarded as a functional part of the family system. The Trobriant Islanders have a different scheme of family relationships and a correspondingly different concept of what constitutes the bereaved. Their emphasis is placed on the persons related to the deceased through his mother. His spouse is not considered as being bereaved.

One study of Ifaluk people by Spiro (cited in Volkart

& Michaels, 1957) found that the immediate survivors displayed considerable pain and distress until the funeral was ended. At that time they laughed, smiled, and behaved as though there was no loss at all. Several hypotheses were offered. Spiro preferred the explanation that child-rearing was not conducted solely in the homes by parents and siblings but involved many persons. Thus the fathering and mothering functions are not identified with one particular person. Upon the death of a family member, the function is carried on by another. The survivors are in effect less vulnerable.

The first significant analysis of the symptomatology of grief (Lindemann, 1944/1963) involved observing 101 patients. Included were psycho-neurotic patients who had lost a relative in the course of treatment, relatives of patients who died in hospital, bereaved victims of the Cocoanut Grove fire and relatives of members of the armed forces. Lindemann did not distinguish normal grief from acute grief. Common to all is the following syndrome:

Sensations of somatic distress occurring in waves lasting 20 minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing and an empty feeling in the abdomen, lack of muscular power and intense subjective distress. (p. 9)

These symptoms were precipitated by social visits, by the mention of the deceased or by receiving sympathy from others. There was a tendency to avoid the syndrome at any cost, to refuse visits that might precipitate this reaction.

The striking features noted by Lindemann were:

1. There was a marked tendency to sighing.

2. Survivors complained about loss of strength, e.g.,
"The slightest effort makes me feel exhausted."

3. Changes occurred in the digestive system, e.g.,
"The food tastes like sand."

4. The sensorium of the bereaved was generally somewhat altered:

(a) A sense of unreality.

(b) A sense of emotional distance from others.

(c) A preoccupation with the image of the deceased.

(d) Preoccupation with feelings of guilt. The bereaved searched the time before death for evidence of failure to do their best for the deceased.

(e) A loss of warmth in relationship to others. There was a tendency to respond with irritability and anger.

(f) For the severely bereaved there was a speeding up of the rate of speech--especially when talking about the deceased. This was accompanied by a restlessness, an inability to sit still, a searching about for something to do while at the same time a painful lack of capacity to initiate and maintain organized patterns of activity.

(g) A sense of surprise to find how large a part of his customary activity was done in some meaningful relationship to the deceased and therefore has now lost its significance. "This loss leads to a strong dependency on anyone who will stimulate the bereaved to activity and serve as the

initiating agent" (Lindemann, p. 10).

Clayton (cited in Kutschner, 1969) conducted two sets of interviews with the relatives of patients who died at Barnes Hospital in St. Louis. Forty were interviewed from two to twenty-six days following bereavement. Twenty-seven were re-interviewed one to four months following bereavement. The first interview revealed only three symptoms: sadness, difficulty in sleeping and crying which occurred in more than one-half of the relatives. In the second interview twenty-two of the twenty-seven (81%) reported feeling better since the first interview. Fifteen percent said that they were not improved. Four percent reported that they were worse.

Knight and Herter (cited in Kutschner, 1969) postulated a time-table of grief which was somehow built within people. Man can anticipate loss. When this happens he begins his grief work prior to bereavement. They cite the case of a University professor who had lived with Hodgkin's disease 10 years beyond the time of diagnosis. Each time he was admitted to hospital he was expected to die. Yet he recuperated enough to return to home and to work. At home intense hostility developed toward him upon his discharge from hospital. The author reasoned that every time he went to hospital his family began to mourn his loss. When he did not die but returned home instead he was met by a group of people who had done sufficient grief work so as to have broken their ties with him.

Fulton (1965) assembled a collection of readings which extended the work of the pioneers such as Freud. The next five studies are contained in Fulton's collection. Shoor and Speed (cited in Fulton, 1965) consulted fourteen adolescents between 14 and 17 years of age who had been sent to a Juvenile Probation Department in California because of illegal behaviour. Not one of them had any previous record of violating the law. All had conformed to societal and parental expectations up to that point. Consultation revealed that each had suffered from the death of a close family member. In some cases the reaction has been delayed.

Brewster (Fulton, 1965) studied six patients who were subjected to separation from their psychotherapist. Three had a psychosomatic disease. Three had a neurosis. After a series of interviews the psychotherapist left for a month's vacation. Although warned in advance, each patient reacted to the separation by regressing. However, gaining lost ground took less time following resumption of therapy than it had at the inception of therapy.

Natterson and Knudson (Fulton, 1965) observed 33 mothers who admitted to hospital their children who had been diagnosed with leukemia or a related disease. All the children were 13 years and under and all died within four months following admission. The mothers went through a triphasic response between time of admission and death. The first was denial of the presence of the disease. In the

second phase they accepted reality and worked to save the child's life. In the third (terminal) they tended to direct their energy away from the individual child. Interests less sharply focussed on their own children became evident. For example, they began to care for other children in the hospital ward.

Stern, Williams and Prados (Fulton, 1965) studied 25 bereaved subjects, 24 of whom were female, between 50 and 70 years of age on the gerontology unit at McGill University's Department of Psychiatry. They found a dearth of mental manifestations, of grief and of guilt feelings. There was a preponderance of somatic illness. The image of the deceased underwent peculiar changes in the consciousness of the bereaved. They noticed an irrational hostility to people in the immediate environment of the survivors and a tendency to isolation. An idealization of the deceased occurred, often to the point of the bizarre.

Helen Deutch (1937) explained the absence of grief in bereaved children on the basis of the assumption that their egos were too weak to carry out the work of mourning. However, she insisted that the grief process must be completed later. She conjectured that since old age is characterized by a weakening of the ego and a relative strengthening of the superego, one would find feelings of guilt or delusions of guilt in the elderly who were bereaved. She found the opposite to be true. She explained this phenomenon by the tendency of the older person to channel

material that was capable of producing overt emotional conflict into somatic illness.

Mathews (1967) gives a subjective and telling account of his own inner reaction to his father's death. His self-analysis strongly suggests that not every aspect of normal grief is expressed. By its nature it is private. Therefore, it does not easily lend itself to study through observation. Mathews reported that well-meant condolences such as, "Isn't it fine that your father lived to be 92?" or "It must be easier for you since he lived such a long time," were not comforting. He disparaged over the lack of understanding of others:

Didn't they realize that to die is to die, whether you are 17, 49 or 110? Didn't they know that our death is our death? And each of us has only one death to die. This was my father's death . . . the only one he would ever have. (p. 108)

Had one accompanied Mathews at the graveside ceremony they would have seen a man who was behaving in an orderly manner with no expression of strong inner feelings. His account of what he was thinking and feeling was in stark contrast to an outward observable reaction:

At the graveside with the simulated grass I wanted to scream. I wanted to cry out to the whole world, "Something is going on here, something great . . . Look! Everybody look! Here is my father's death." (p. 119)

A recent study (Parkes, 1973) involved working with 49 widows and 19 widowers all under 45 years of age, of varied social, racial and religious backgrounds living in the Boston area. The purpose was to discover why some

people came through the experience of bereavement to make a good adjustment while others had lasting problems in coping. Each survivor was interviewed in their home at three weeks, six weeks and thirteen months following the death. Most of them were re-interviewed two and three years later. So that an empathic relationship might be built and information about emotional issues might have a better chance of surfacing, the respondents were encouraged to talk freely. Only toward the end of the interview were a number of fixed questions asked. All interviews were tape-recorded and data coded (for statistical analysis) independently by two coders who listened to the tapes and made a series of assessments. Only those ratings which were reliably coded by both coders were used in the analysis of the data.

By comparison with the control group the bereaved group had three times as many hospital admissions during their first year of bereavement and spent considerably more time sick in bed than the control group. One-third of them consulted a professional person for help with an emotional problem during the first year. One-third reported problems with sleeping, appetite, consumption of tobacco, alcohol and tranquilizers. Widowers in particular reported more acute physical symptoms (sweating, dizziness, trembling) than the control group. The bereaved reported greater difficulty in making decisions and more intense feelings of loneliness. They were more depressed than those in the

control group. This condition did not improve until well into the second year.

To explore what distinguishes those who make a good adjustment to bereavement from those who do not, Parkes and his colleagues devised a number of rather complex "outcome measures." These measures enabled them to identify subgroups with extremely good and extremely bad outcomes. Next they carried out a discriminant functions analysis to discover which of 18 key measures derived from the three week and six week interviews successfully distinguished the two groups. The results of this analysis are shown in Table 1 in which the seven variables which made the greatest contribution to predicting good or bad outcome are listed. (See Table 1, Appendix A.)

The best single indicator was the "Coder's Prediction of Outcome." This was the general assessment of the coders after they had listened to the first two interviews. It was not a blind guess because the investigators based their assessment on previous research and experience.

The second two features of "yearning" and "attitude to own death" both reflected the respondents' state of mind after bereavement. Respondents who seemed to the coders to be pining intensely and continuously for the dead person and who said they would welcome death, were more likely to be found in the "bad outcome" group a year later.

The fourth item indicated that "bad outcome" was associated with a brief terminal illness of the deceased.

It was derived from a five-point scale whose points were labelled six months or more, two to five months, three to thirty days, one to two days and instantaneous. Item five indicates that people of low social class were more likely to be found in the "bad outcome" group. Both anger and guilt, as assessed by the coders, were common in the "bad outcome" group.

Evidences of Abnormal Grief

Abnormal grief refers to a grief reaction which continues over a longer period of time than seems warranted, which does not gradually resolve itself in a reasonable amount of time and which has unexpected and often excessive components which seem inappropriate to circumstances of the bereavement.

Freud (1917/1949) distinguished between mourning and melancholia. The symptoms of melancholia are:

1. The experience of profoundly painful dejection.
2. The loss of interest in the world.
3. The loss of capacity to love.
4. The lowering of self-regard to the point of self-reproach, self-reviling to the point of delusional expectation of punishment.

The symptoms of mourning (normal grief) and melancholia (a variety of abnormal grief) were the same with the exception that in mourning there was no loss of self-esteem. In melancholia the loss of a loved one provided a chance for the ambivalence in love relationships to make itself

felt and come to the fore. Thus the mourner saw himself not just as a mourner but as one who was to blame for the loss of the loved one.

Lindemann (1944/1963) referred to morbid grief reactions which represented distortions of normal grief. The most striking and frequent of the morbid reactions was that of delayed grief. For example, a 17 year old girl whose parents were killed in the Cocoanut Grove fire showed no sign of grief for 10 weeks. Then she began to have marked feelings of depression, tightness, intestinal emptiness and a preoccupation with her deceased parents. A railroad worker began to experience grief for the first time, 20 years after his mother had committed suicide.

Lindemann concluded that if

the bereavement occurs at a time when the patient is confronted with important tasks and when there is a necessity for maintaining the morale of others, he may show little or no grief reaction for weeks or even much longer. (p. 12)

Lindemann's study revealed that within the period in which the bereaved had lost but not yet experienced his grief, alterations in his conduct occurred. These may be considered as surface manifestations of delayed grief:

1. An overactivity without a sense of loss.
2. The acquisition of symptoms belonging to the last illness of the deceased.
3. A recognized medical disease such as colitis.
4. Some alteration in his relationship to his friends and relatives.

5. Furious hostility toward specific persons.
6. A woodiness springing from the effort to control hostility.
7. A lasting loss of patterns of social interaction.
8. Activities detrimental to his own social and economic existence.
9. Agitated depression which at its worst had an element of suicidal thinking.

Rogers (1953) did not distinguish between normal and abnormal grief as such but did indicate that the memory of a painful event which has not previously been reviewed was likely to bring back the emotions which accompanied the experience. This was often the basis of motivation for a variety of behaviour designed to avoid acceptance of one's loss, e.g., changing the subject when it concerned the deceased, or moving geographically from the place of death or the former residence of the deceased. Rogers noted that guilt feelings which are subconscious led to grief of a more morbid quality. A mother who was antagonistic toward her pregnancy suffered the loss of her child. She interpreted the child's death to be the direct result of her wish that she would not have a baby.

In the Harvard study (Parkes, 1973) the most significant of the "bad outcome" scores was reached by combining assessments on a number of psychological, social, and physical health measures. This was called a "combined outcome." Table 2 shows the correlations between various

antecedent factors relating to the mode of death and the "combined outcome" 13 months after bereavement. From these it appeared that it is not so much the presence or absence of spouse or the communication with the dying but the duration of time during which the survivor had a chance to prepare himself for the coming bereavement that determines the outcome 13 months later.

Janis (cited in Janis, Mahl & Smith, 1969) reported two compensatory mechanisms described in psychoanalytic literature. The first was unconscious identification of the survivor with the deceased. For example, following the death of a father a son was likely to show a change in physical appearance, mode of dress or mannerisms which resembled the dead parent. The second was that of postponed obedience. This was evident in cases where the mourner suddenly accepted and rationalized parental attitudes, ideals or values which he had rejected while the parent was alive.

Stages of Grief

The information available at the present tends to be the product of the experience of those who work professionally with the bereaved (e.g., clergymen and medical doctors) rather than those who have attempted an empirical study under proper controls.

Oates (1954) suggested that on the basis of his experience, a grief-stricken person moves through six phases which may or may not be telescoped into each other:

1. The shocking blow of the loss-in-itself. Shock is the ruthless entry of the external world into the subjective realm of the survivor. It amounts to being struck, assaulted by reality. The person's anxiety has not yet been activated. The everyday momentum of his life continues so that he continues to act automatically as though no change in his relationship has occurred.

2. The numbing effect of shock. Following the shock, this phenomenon is equivalent to the freezing effect of a local anesthetic. The reality of the loss then descends gradually upon the survivor. A person complains about not being able to feel anything.

3. The struggle between fantasy and reality. For a time the person goes on acting as if the deceased is still there. He struggles over accepting the reality of the loss. "The whole inner selfhood of the individual tends to prefer fantasy to reality. An inner wall of fantasy is built against the reality" (p. 53). A seven year old child whose mother had died a month before played roughly with his dad on the rug. Suddenly he cried out, "Mommy, Mommy, make Daddy quit" (p. 53).

4. The break-through of a flood of grief. When the fantasy disintegrates, grief floods over the individual. If there was conflict in the relationship the pain is all the more agonizing. This is particularly evident in the case of a death following a divorce.

5. Selective memory and stabbing pain. After several

recurring waves of grief expression, the process levels off. Particular persons, objects or activities may trigger in the survivor an association with the deceased. This is followed by stabbing pain. Day-dreaming may occur throughout the daytime and bereavement dreams, ridden with anxiety involving erotic and hostile material happen at night.

6. The acceptance of loss and the reaffirmation of life itself. The individual goes through a death and resurrection experience of his selfhood, "first rejecting life in the face of death and then accepting death in the face of life The individual does this by taking the lost image of the loved one into his own concept of himself" (p. 55).

Westberg (1961) suggested that while no two people go through the process in exactly the same way, the following are typical stages through which the bereaved will pass:

1. Shock.
2. Emotional release.
3. Symptoms of physical distress.
4. Inability to concentrate on anything but the lost object.
5. Feeling of depression and gloom leading at its worst to a desire for suicide.
6. Sense of guilt.
7. Sense of hostility, often directed to the doctor, nurse or minister.

8. Unwillingness to participate in the usual patterns of conduct. This may be the mourner's way of reminding others of the loss, of protesting the indifference of those who take up life again and for whom this death will make little or no difference.

9. The gradual realization that withdrawal from life is unrealistic.

10. Readjustment to reality. Although his major grief work has been done, the survivor will experience shorter cycles in which he will re-experience some of the above phases less intensely.

Hodge (1972) recognized ten stages of grief and insisted that the bereaved must go through all stages. If he missed a stage, something was wrong:

The grief work must be done completely, or illness will result. Many of these phases may be gone through in a matter of hours or days--a matter depending upon the individual--but the acute process is normally completed from six to twelve weeks . . . and the entire process should be completed within two years in a healthy situation. (p. 232)

Hodge listed similar stages in the same sequence as Westberg:

1. Shock and surprise.
2. Emotional release.
3. Loneliness. Even before the funeral, loneliness, isolation and depression begin. The funeral brings his loss into a sharper focus. The loss of the presence and support of friends who return to their usual routine accentuates his sense of loss.

4. Physical distress with anxiety. He worries about his future.

5. Panic. The survivor finds he can concentrate on nothing but the deceased. Accordingly, he begins to think that there is something wrong with him.

6. Guilt. Partial or complete interruption of the process often occurs here. Almost certainly it leads to a depressive reaction.

7. Hostility and projection.

8. Lassitude. The bereaved recognizes that others expect him to stop grieving. His emotional outbreaks of tears, frustration or depression are not as well tolerated several weeks after the death. This suffering in silence is one of the most difficult phases of the process.

9. Gradual overcoming of grief. A noticeable change in his adjustment to the new status occurs as early as four weeks.

10. Readjustment to reality. Though the acute phase is normally completed within 12 weeks, the readjustment continues for up to 24 months.

The studies of Lindemann and Parkes followed more closely the method of scientific enquiry through using selected instruments by which to observe. Referring to normal grief, Lindemann (1944/1963) found that

the duration of the grief reaction seems to depend upon the success with which the person does the grief work, namely, emancipation from the bondage of the deceased, readjustment to the environment in which the deceased is missing and the formation of new

relationships. (p. 11)

One significantly large obstacle was the tendency to avoid the distress connected with grief. The men survivors of the Cocoanut Grove fire appeared to be in a state of tension, with tightened facial musculature. Relief of tension occurred as soon as they became willing to embark on a program dealing with the memory of the deceased. Within eight to ten interviews over a period of four to six weeks, it was possible to settle an uncomplicated, undistorted grief reaction. This was true in all but one of the thirteen Cocoanut Grove fire victims.

There was a similarity in the findings of Oates, Westburg, Hodge, and Lindemann. Hodge and Lindemann suggested a time limit for the acute phase of grief as 12 and 6 weeks respectively.

Parkes (1973) found that the grief process was very different for survivors of those who had suddenly died in the course of a chronic illness which was not expected to be fatal or had died following a brief illness, than for those who had longer time to prepare for their bereavement. His findings are so significant that they will be reviewed in detail later in this chapter. It is sufficient to note here that the "long preparation group" experienced a process more closely resembling the stages as noted by Oates (1954), Westberg (1961), Hodge (1972), and Lindemann (1944). Thirteen months following the death 60% of them were assessed as having a "good outcome" meaning, amongst

other things, an acceptance of the death, a good attitude to the future and few problems regarding role functioning (see Table 3, Appendix A). Two to four years following death this increased to 68%. On the other hand only 13% of the "short preparation group" were rated as having a "good outcome" at 13 months. Two to four years following death this had dropped to 6%. Parkes concluded that the unexpectedly bereaved was still struggling with his past two to four years after his loss has occurred. Grieving had become a normal part of his life. Typical was a sense of the presence of the deceased, an attempt to behave according to the perceived wishes of the deceased and a sense of overall anxiety.

Hodge may be allowing for the "short preparation group's" "bad outcome" when he indicated that readjustment for the bereaved continues up to 24 months. However, he did not state this. While Lindemann did not link "short preparation" with morbid grief reactions, he did indicate that the most striking and frequent of the morbid grief reactions was that of delayed grief, which according to the Parkes study, was linked with "short preparation."

Parkes (1973) found that adjustment difficulties in his population of widows and widowers were significantly associated with a brief terminal illness in the deceased. He divided his subjects into "short preparation" (s.p.) and "long preparation" (l.p.) groups. The s.p. group was determined on the basis of a 5-point scale whose points

were labelled "6 months or more," "2-5 months," "3-30 days," "1-2 days," and "instantaneous." Those who had a high score on this scale had either had a short illness or died from an accidental cause.

Three weeks following death the first interview occurred. Sixty-three percent of the s.p. group reported an immediate reaction of disbelief as compared with 24% of the l.p. group (see Table 4, Appendix A). The process of grieving in the two groups was different with 69% of s.p. group and only 37% of the l.p. group reporting feelings of guilt and self-reproach and 33% of the s.p. indicating resentment towards the deceased for leaving as opposed to 7% for the l.p. group.

The overall reaction of the s.p. group was considered similar to pathological reactions to bereavement while the l.p. group was less confused, had less difficulty accepting reality and showed little evidence of guilt or anger. Parkes speculated that the former group of survivors had less opportunity to pay the unpaid debt consisting of unfulfilled intentions, harsh words and angry feelings which had passed between them. The latter group did have an opportunity to make restitution for any deficiencies in the relationship, i.e., they have a chance to "do everything that is possible for him" (the patient), as the saying goes.

Six to eight weeks later 38% of the s.p. group as compared to 65% of the l.p. group initiated and accepted more invitations to be with others. Only 43% of the s.p.

group had visited the grave as yet, while 70% of the l.p. group had already done so (see Table 5, Appendix A).

One year later there was very little change in the s.p. group. Forty-eight percent of it continued to express feelings of guilt or self-reproach (compared with 18% of the l.p. group). Two-thirds of the former group were not working outside the home while only one-fifth of the latter group were in this category.

Two to four years later the members of the s.p. group seemed unable to throw off the ties of their dead spouses. It was not so in the case of the l.p. group as indicated in Table 6. "Whereas the widow or widower who is prepared for bereavement soon gives up the struggle to recover the past, the unexpectedly bereaved is still struggling two to four years later" (p. 21).

Janis (Janis et al., 1969) recorded the work of Robertson and Bowlby who observed more than 50 school children confined to a hospital or sent to a nursery so that the mother might pursue a full-time job. They noted three emotion phases in the following order: protest, despair and detachment. The longer the period of separation, the greater were the chances of entering the third stage.

Management of Grief

Treatment

The treatment of grief suggested in the literature is neither explicit nor detailed. Most often the reader can

only infer what treatment the authors used or would suggest. In general, it appears to this writer that the treatment of grief is more related to the profession of the helper than it is to man's understanding of the needs of the bereaved. For instance, clergymen tend to see the bereaved as having spiritual needs. Psychologists see them as having psychological needs which have to be worked through. Medical doctors tend to see them as people suffering from physiological changes.

Lindemann (1944/1963) saw treatment in terms of enabling the bereaved to do his grief work, viz., becoming emancipated from the bondage of the deceased, readjusted to life without the deceased and the formation of new relationships. He implied that this was accomplished by the interview method in which he would encourage the bereaved to talk about his memories of the deceased. Painful memories were definitely not avoided. Tears were encouraged. When distortions of normal grief were detected, attempts were made to transform them into normal reactions. Other surface manifestations such as colitis, over-activity, hostility, woodenness and depression were regarded as clues of distorted grief reactions which could be transformed to normal grief through the procedure noted above.

Perls (1969) is not especially associated with the management of grief yet has made an important contribution. He theorized that the structure of neurosis consists of five layers: the cliché, the phony, the impasse, the

implosive, and the explosive layer. Healing comes from moving into the explosion layer where one can explode into grief orgasm, anger or joy. At that point one's grief or anger has still to be worked through. The so-called "breakthroughs" of Reichian Therapy are as little useful as "insight" in psycho-analysis. Things still have to be worked through. The following is the case of one who has progressed through the various layers into explosion into grief:

- F. Close your eyes again. Give us the exact details of how you hold back your tears. Which muscles do you use, and so on.
- B. I'm not feeling it now. I can remember holding them back, tightening my throat, clenching my jaws.
- F. Can you do this now? (through his teeth). "I won't cry."
- B. I won't cry.
- F. Yah. Clench your jaw. Hold it back.
- B. I won't cry. I won't cry.
- F. What's the situation? What's the occasion?
- B. When I'm not crying?
- F. Yah.
- B. I was at a funeral (voice quavers). I'm at a funeral.
- F. Who?
- B. An old man who died, whom I liked very much.
- F. Go back to his grave and say good-bye to him.
- B. (Very soft voice) Good-bye.
- F. What's his name?

B. Curt.

F. Say, "Good-bye Curt."

B. Good-bye Curt. I've really missed you. (Almost crying.) I wish I could have expressed more how I like you, when there was time.

F. Let him talk back. Give him a voice.

B. I knew you liked me . . .

F. Tell him a little bit more about how you appreciated him.

B. He was so gentle.

F. Say this to him.

B. You were so gentle. Gentlest person I knew. No hostility toward anyone. Incredible . . .

F. Can you see him? Can you see your friend? Go touch him and say good-bye again.

B. Good-bye (starts to cry). Good-bye . . . (cries). Good-bye. It's hard to say good-bye . . . (sobs).

F. Come back to us. How do you see us now?

B. I don't . . .

F. Well I don't feel that your good-bye is finished. You still have to do more mourning there. Pull out your roots again and become free to get new friends.

This is one of the most important unfinished situations: if you haven't cried enough over a beloved person whom you have lost . . . which usually takes a year until you take up all the roots from a dead person and can apply yourself again to the living ones. (pp. 175-75)

Again, Perls (1970) demonstrated that dreams could be useful in doing grief work. The client was encouraged into the explosion layer to deal with the unfinished grief over her mother's death. After her explosion she says "I'll let you [Mother] go. I'll let you go. Mama, (softly)

please go" (p. 222) .

Switzer (1970) saw grief as essentially acute anxiety whose basic force is the separation fear. Believing that language in the infant and child performed the functions of communicating basic survival needs, winning parental approval and holding parents emotionally close even when they are absent, he saw language as among the first learned mechanisms of anxiety reduction. "Language is a learned means of overcoming separation" (p. 195) .

Thus Switzer saw treatment of the grief-stricken as consisting chiefly of enabling them to verbalize. The counsellor was to encourage conversation around the following foci:

1. Release of negative emotions through working through hostility and guilt.
2. Affirmation of oneself.
3. Breaking libidinal ties.
4. The resurrection of the deceased within the self of the bereaved. To the extent that persons have been emotionally involved with one another, making an effective investment in one another, to that degree they have made identifications of their lives. One's self has certain aspects of the life of the significant other as a living component of it. When the other dies, the self is perceived as threatened with death by the loss of the other. But the external event of the death of an emotionally significant other need not annihilate the self. Rather, the other

which is within one can be re-affirmed as living as a part of oneself.

5. Renewal of relationship with others.

6. Rediscovery of meaning. Yet without the above needs being fulfilled, meaning will be missing.

Bachman (1964), writing specifically for clergymen, suggested that they should attempt to be good listeners. Specifically he considered the following technique to be important:

1. Start with the person where he actually is.

2. Accept the person where he is.

3. Clarify his feelings toward the deceased.

4. Indicate to him that you understand him.

5. Help him focus on alternative courses of action when this is appropriate.

Hodge (1972) writing chiefly for psychiatrists and physicians suggested the following five-point summary for management of grief:

1. Intervention by the physician during the acute phase. Being available to the bereaved was important.

2. Medication. A mild stimulant such as Desamyl or Ritalin may be of some value. A night-time sedative may be in order. Sometimes the mild tranquilizers such as Librium, Valium and Serax were helpful. It was important not to sedate the bereaved too much.

3. Focus on the entire family. It was important to support the family integrity so as to prevent its loss of

strength through fragmentation. The quick trip to forget should be discouraged.

4. Promote grief work through encouraging the expression of feelings verbally and even through writing letters. Schedule a series of consultations of 20-30 minutes each.

5. Maintain hope by painting a realistic picture of the length of time it will take before they feel normal again.

A Survey of 33 Family Practitioners

(See Appendix B.) In an increasingly secular society a greater percentage of people suffering from loss of a family member go to their medical doctor for aid. Since there was a dearth of printed material on this subject, it was decided to survey a number of doctors to discover how they treated the bereaved. Consultation with the Medical Director of an active treatment city hospital led this writer to the conclusion that more bereaved persons were treated by Family Practitioners than by any other group of physicians. Accordingly a questionnaire was devised for survey purposes. A meeting was held with the Head of Family Practice at the same hospital for the purpose of wording the questionnaire in a way that would be readily understandable by medical doctors. Thus such a phrase as "complaint of the common cold" was changed to "complaint of the upper-respiratory system."

The questionnaire consisted of eleven questions.

Forty-six were mailed to members on the Active, Senior Active, Associate, and Courtesy Staff of the Department of General Practice of the hospital. Of the 46 letters mailed 32 were returned, representing a response of 70%. The results are summarized below.

Sixty-one percent of the Family Practitioners (F.P.) saw one to ten patients for reasons of bereavement over a one-year period. Twenty-one percent saw between 11 and 15, and 9% saw up to 30 patients. Thus 97% of F.P. saw one or more patients who have been bereaved over the period of one year. Forty-two percent of the patients treated make one to two visits while 48% made three to four visits. No one reported seeing a patient over eight times for reasons of bereavement.

Fifty-two percent indicated that there was a tendency for surviving members to become ill at the time of loss. However, 42% indicated the opposite, while 6% qualified their answer by suggesting that the illness occurred sometime "later." If "later" had been added as an option, perhaps more respondents would have checked it. Two respondents who answered "No" did check a specific complaint for the next question.

As to the complaints of the survivors at the time of bereavement, 53% were judged to be of a "psychological" nature while 47% were judged to be physical ("upper respiratory," "gastro-intestinal," "central nervous," and "cardiac system"). Of the total treatment given 33%

involved "listening to the patient." "Giving the patient information" accounted for 18%. "Explaining the nature of the grief process" accounted for 23%, and "encouraging the patient to make use of the religious resources in the community" for 17%. Of the 31 F.P. who answered this question, 48% used three of the methods referred to, 23% used all five methods, 10% used 4 and 10% used only 1 (giving the patient information).

Is it best for survivors to experience the acuteness of the loss at the time of death? Eighty-nine percent answered positively. How long does it take the "average" bereaved to function "normally" again? Seventy-two percent estimated between 1 to 3 months. No one indicated that normal functioning was delayed beyond 24 months. Yet, with regard to the length of time required to feel "normal" again, 74% suggested longer than 3 months and 6% suggested longer than 24 months.

Regarding the best use of anxiety reducing medication, 19% suggested that it not be used at all, 9% that it be used to help the patient function, 6% that it be used for a short term only, 3% sparingly, and 33% that it be used to induce sleep so that the patient's energy was conserved. Does taking medication lengthen the course of the "normal" grief process? Fifty-three percent said that it did not, 40% thought that it did and 6% expressed no opinion.

Two of the respondents saw anger as part of the grief process and acknowledged that it posed a problem for

physician-relative (of the dying and/or deceased) communication. Two mentioned that each case differs tremendously and therefore averages are of no value. It was twice noted that some symptoms of grief do not emerge until sometime after the loss has occurred.

Rites and Customs

A series of detailed articles edited by Hastings (1912) reviewed the rites for the disposal of the dead amongst primitive man and twenty-five racial and religious groupings of mankind. Rites and customs to cope with the experience of death have varied greatly through history. Even within a country at any given period of time customs have varied according to wealth, rank, occupation and religion so that "no single succession of circumstances may be taken as typical" (p. 505).

Rogers (1963) in a brief introduction to Eric Lindemann's contribution to our understanding of grief indicated that the rites and customs of dealing with grief seemed to have served some very useful purpose, even though they appeared to be superstitious and magical in nature. He noted the following:

1. Actualizing one's loss. Such rites as washing the body of the deceased, combing the hair, holding feasts for speeding the spirit on its way and leaving food with the body so that the spirit might prosper in the next life serve this function.

2. Expressing the sense of loss. The beating of

breasts, wailing and tearing of hair were attempts to ritualize loss.

3. Freeing the bereaved from the image of the deceased. In one primitive tribe a widow returning home after the burial of her husband ran through the woods following a zig-zag course so that her husband's ghost would not follow her.

4. To help the bereaved adjust to the world from which the deceased has gone. Hindus removed ashes from the fire which cremated the body and poured a ring of water around the house of the bereaved to shut out the ghost of the departed. Then a new fire was kindled to serve a new era.

We have no way of estimating how effective these customs were in enabling the bereaved to cope with their grief. In modern times, however, we are discovering that our efforts are not always adequate. Freud (1917/1949) discovered in working with melancholia that he was also dealing with unresolved grief. Klein (1940) in dealing with manic depressions found that her patients were often struggling with unresolved grief. Lindemann found bereavement to be the most important precipitating factor in ulcerative colitis.

Mitford (1963) stated that the rationale for funeral rites has changed in the last century. Conceding that they may have served a useful function for the bereaved, she was convinced that they have meaning only for the

funeral industry, currently.

A brief look backward would seem to establish that there is no resemblance between funeral practices today and those of 50-100 years ago and that there is nothing in the history of Western civilization to support the thesis of continuity and gradual development of funeral customs. On the contrary, the salient features of the contemporary funeral (beautification of the corpse, metal casket and vault, banks of store bought flowers) are all of very recent vintage in this country and each has been methodically designed and tailored to extract maximum profit for trade. (p. 190)

The American funeral director originated at the beginning of the twentieth century. He performs the functions previously done by the cabinet maker (who built the coffin) the drayman (who transported the body), and the custodian (who rang the church bell and dug the grave). He now supplies the setting in which the funeral takes place, thus almost eliminating the use of the church sanctuary as a context for funerals.

Mitford contended that the major western faiths have little to say about how a funeral will be conducted. She noted a 1959 study by Robert Fulton of the University of Illinois on the attitude of the clergy to funerals and funeral directors. Fulton found that while a majority of Protestant and Roman Catholic clergy saw the modern funeral as adequate, the majority of Protestant clergy advocated such changes as discontinuing open caskets, the use of flowers, the tendency to conceal the reality of death, and expensive funerals.

If, as Mitford claimed, the funeral industry's

primary aim was to serve itself rather than the bereaved, perhaps the rites and customs of funerals in the western world have ceased to be a helpful means for enabling the bereaved to cope with their grief.

At this time there is little or no literature on the value of a recently developed method of disposing of dead bodies through donation to medical science. Increasingly, there is a demand for some body parts such as eyes, kidneys and hearts. Nor have any rites been invented specifically for this purpose. It could be conjectured that donation of bodies for the purpose of medical research and the building up of supplies of re-usable parts would be a more meaningful way of disposing of the dead. Any funeral rites developed to symbolize this happening might be a more useful instrument in the management of grief than present burial customs.

Disclaimer

The following are actual case studies but names and vocations have been changed to preserve the identity of the persons involved.

CHAPTER III

CASE STUDIES

A Summary of the Cases Studied

Deceased

Immediate Survivors

Case Study One:

James A.	Jane A., wife, 40's
Male	Two daughters, 20's
Middle-age	One daughter, teens
Professional	One son, teens
Instant death	

Case Study Two:

Jack B.	Mabel B., wife, 40's
Male	Two sons, 20's
Middle-age	
Professional	
Instant death	

Case Study Three:

George C.	Nancy C., wife, 30's
Male	Three sons, pre-teens
Middle-age	One daughter, infant
Professional	
One year illness	

<u>Deceased</u>	<u>Immediate Survivors</u>
Beth D.	Bill D., father, 20's
Female	Rene D., mother, 20's
Pre-school	Barbara D., sister, pre-school
Instant death	Mr. and Mrs. D., grandparents, retired
	Mr. and Mrs. W., grandparents, retired

Case Study One

Census and Personal Data of the Deceased

James A. was a middle-aged husband of Jane and father of four. He was born in Canada and had served overseas during World War II during which he met Jane. She returned to Canada as his bride at the conclusion of the War. For the past 28 years he had been employed in a local business. His death was completely unexpected because none of the survivors had any reason to suspect that his job involved any kind of physical danger. He had been in good health, was seemingly well-adjusted and happy with all aspects of his life.

Census and Personal History of the Survivors

Jane A. was middle aged. She was in good health, active in church and community activities and was employed part-time in her husband's company. For most of her married life she had the responsibility of raising their four children, her husband being away on business matters. The two eldest daughters were married leaving one teen-age

daughter and a teen-age son at home. Their family life could be described as being reasonably happy.

Immediate Reaction to Bereavement (1-30 days)

For our initial meeting all of the family and several friends were gathered. Jane did most of the talking, narrating the known details of the accident. She revealed little evidence of grief. She asked why such a thing should happen and answered her own question by quoting the words of the first minister to call, namely, that "He had done his work here and God had something else for him." Mention was made of two recently bereaved women who had called on her; of her gratitude toward the family of the other men and a city official who had telegraphed their condolences. She expressed concern over the second oldest daughter who cried a lot, over the son who exhibited no sign of grief and her mother-in-law who had become very quiet.

On the day of the funeral Jane appeared composed and although there was some evidence of tears she maintained control of her feelings. Following the ceremony she appeared sociable and verbalized appreciation to many who had come from distances to spend the day with her.

At our third meeting, three weeks following the death, Jane reported that James' mother bothered her because she had become so silent. Jane was involved in determining her financial situation, applying for a particular pension and selling a car. She mentioned how obliging a civil

servant had been to her when she needed information about the death certificate. At this time Jane reported that she had not yet missed James and that she kept expecting to see him coming up the front sidewalk on a Friday evening (when he had customarily arrived home).

The fourth visit occurred in my office. Jane talked quickly about the government requiring James' birth certificate before it would issue a death certificate. The baptism certificate she presented was not acceptable. This prompted her response: "If it was good enough to get him into the Army, it should be good enough for this." Government agency delays irritated her and she reported venting her feelings on a particular civil servant. Returning by car, she swore all the way home. "James would have been proud of me," she reported.

A letter from her husband's business associate contained a proposal to purchase the business. The details involved were somewhat complex. This sparked her to remark, "Maybe that's why it happened--to make me make use of my brain. I haven't had to think like this for years. James did all the thinking." Jane went on to indicate that she was pleased about buying the business car her husband used.

Further on in our conversation she told the author about a friend who would not speak to her own husband:

I couldn't live like that. James and I had our ups and downs but there was love there. And it kept surfacing. We both knew it. The morning he left,

he kissed me awake. There he was: dressed, shaven, ready to fly to _____ and I thought to myself, "you're a beautiful man."

At this point another clergyman whom she had previously known as a neighbor entered my office unannounced. Jane began to relate to him the incidents she had previously told me but this time with noticeably increased speed.

Conclusions

By the end of the first month Jane had become very busy with the real concerns of settling an estate but had not yet revealed what is often regarded as the major symptom of grief, viz., an excessive display of tears. She seemed especially grateful to and strengthened by kindness shown to her, e.g., the two recently bereaved widows who visited her. She verbally expressed more concern about other members of the family. Dependency upon others with legal and business expertise as well as a need to befriend those who helped her in a professional capacity was evident.

That she did not miss her husband up to that point is probably explained by the fact that he tended to be away for one to two weeks or more at a time. An increase in the rate of talking along with a compulsion to achieve something was noticeable. Anger in response to frustration was evident along with a feeling that others might be taking advantage of her, e.g., her husband's former partner.

An attempt to find some purpose for James' death by the explanation that she would now be forced to use her

brain seemed to bring some satisfaction. The purchase of her husband's business car seemed to satisfy her too. And she smiled when she evaluated her marriage relationship and concluded that it compared very favourably to that of other couples. Finally, the need to share her experience was apparent.

Early Reaction to Bereavement (2-6 months)

During our fifth meeting Jane was engrossed in her attempt to settle insurance claims and some clerical errors by an insurance company. Because of one error, she verbally attacked a female clerk and reported feeling justified in this action. She had lost 15 pounds in the last six weeks and felt like throwing-up at any time. Her facial expression was one of being nauseated.

She reported missing James the most in the morning when there was no one up at 6:15 a.m. for whom to make breakfast and in the evening when there was no one to talk with prior to falling asleep. As yet, she had not unpacked his suitcase nor removed his clothes from the bedroom closet. "There is an odour about them. At this point I can't bear to lose that." Nevertheless, she was surprised to know that her son had collected his father's obituary notices from various newspapers. When asked about why he wanted his father's jacket he replied, "Dad had a lot of things I wanted."

Jane exhibited a general tiredness. She wondered if this experience would change her permanently: "Will I ever

be able to joke again? Or tease?" A business associate who was unaware of James' death called for James and was told, "He's not here just now." She talked of her own death and referred to death as an opaque curtain through which one passes. "Don't feel sorry if I should die," she had told her oldest daughter, "I'll be with Daddy."

At our sixth meeting Jane related that she had unpacked his suitcase and had cried. This was seven weeks following her loss. The reality of his death broke in upon her. "Up until then I kept it down. Every time I felt I was losing control, I would swallow, push down." She had sold James' recreational camper. This transaction precipitated tears too. "If James was really coming home, I would not have sold it."

She reported a dream in which her husband had crawled into bed with her. Awakening she found the family dog trying to get up on the bed. Talk of the deceased amongst family members was practiced daily. She seemed pleased that her son wanted his father's radio so that it could be set to come on at the same time in the morning "just like it used to be."

Our seventh meeting was late at night. The oldest daughter called me, indicating her mother needed help. Jane was sitting in the kitchen sobbing uncontrollably. Her face revealed that the crying had been prolonged. Her body was shaking steadily, the movement being more pronounced in the torso area. She said that she felt lost,

did not want to live and had been crying for three days. She had exploded in tears when the camper had been picked up. "It was as if all he had dreamed of was going. Our future was gone." There seemed to be feelings of sympathy for his loss of life, the demise of his dreams as well as regret over the curtailment of their joint hopes and plans.

She had begun part-time employment which required that she take an exam. Vomiting and loss of sleep occurred before this event. "Tranquillizers aren't helping. I wish my ulcer would perforate and I would die too. I'm afraid . . . I'll never be able to control myself again," she reported.

By the eighth meeting, two weeks following, Jane had regained most of her control. Her concern widened to such items as selling her husband's business, the rivalry between the children and her loss of status (from being a Company Director to part-time casual labour). At a family conference the youngest daughter explained that she was retreating from her mother by staying away more because of her "fear of being swallowed up." Yet this behaviour tended to increase Jane's loneliness.

Some over-idealization was apparent when Jane said, "James was the best construction man in Canada." This sentiment had been expressed from the beginning of her grief. She was sleeping between three and five hours per night with the result that her medication had been changed. Her doctor told her that she would be depressed for up to

one and a half years.

At the ninth meeting Jane seemed hostile. She expressed strong anger toward her husband's junior partner who had purchased the business from her. Her anger was focussed on two items of office furniture which she had casually requested prior to the purchasing negotiations. When the new owner refused to give them to her on the grounds that the equipment went with the business she became very indignant. Her emotions appeared reminiscent of her feelings about the man who purchased her husband's camper. Concern was expressed about her son's poor academic performance in the first six weeks of the school term and about his failure to show obvious symptoms of grief.

To a service repairman who called she referred to her husband's activity in the present tense: "James has the fridge on wheels." Later on she said, "I can accept that he won't be coming back but sometimes I think, 'Oh, he'll be back.'" She reported about her legal activities in settling the estate and indicated her gratitude for competent legal aid. This meeting was concluded by an extended repetition of her husband's achievements followed by a shorter resume of her own. She reported: "He was a man of integrity. Everybody knew it . . . he knew his business" and "I was a good book-keeper, if I do say so myself . . . I looked good . . . he was proud of me."

At the tenth meeting Jane talked for the first time ("This is the first time I have told anyone") of her

suicide thoughts and wishes in the first month of bereavement, e.g., "I wished a bus or car would hit me." The conversation again focussed on the security concerns of pensions, insurance, compensation and investment of her estate. Her thoughts roamed back to her mother's death (when she was 23 years old) and how that experience had prepared her for the death of her husband. Concern was expressed about her youngest daughter who had been found crying in the washroom of her office building. When another secretary tried to extract her she refused, sobbing, "I want my father." This visit concluded with Jane saying:

I know he's not coming back anymore, though I don't like the prospects of that . . . but I'm not holding back the children. They are free to come and go. And this way, when the time comes, I don't expect them to limit me--whether it involves moving from this house or a re-marriage.

She reported having lost 30 pounds.

The eleventh interview followed a committee meeting of which we had both been members. She had expressed some frustration at knowing what kind of serviceman to call for certain house repairs. When the other members of the committee did not respond to her she expressed several feelings and sentiments. She was angry at being referred to as "a little old widow lady" (the reference was not meant for her). During our interview she elaborated: "If I wanted to remarry, it would have to be someone special . . . there will never be another James." She

talked about the threat she sensed she posed to other women: "If they think I'm going to let myself go to pot, they're crazy . . . I never thought single status was this bad." This visit ended with Jane relating the abilities of her oldest daughter.

Conclusions

Irritation over clerical mistakes which caused further delay in settling the estate was apparent. Noticeable too was a loss of 15 pounds of body weight. Control of grief expression, maintained for nine weeks was accompanied by feelings of nausea, continual swallowing. The deceased tended to be missed at specific times of the day, e.g., breakfast or bedtime. All the while there was a tendency to preserve visible evidence of the deceased's existence (clothes in his suitcase and closet). There was fear of not being able to return to normal. Sometimes the energy required to face James' absence was too much so that denial became easier, e.g., "He's not here just now.

When crying did come it lasted for three days, being accompanied on the last day by uncontrolled sobbing. The latter went on for about 6 hours. During this period the wish to die was expressed in strong terms as was the fear of loss of control. Dependency on other family members was evident but not overly pronounced. Inability to sleep (three to five hours per night) is very much a part of her life at this point in time. Following the seventh meeting during which the sobbing occurred there were no more

reports or facial appearance of nausea.

Anger, without due cause is evident around the office furniture items. Her son's lack of breakdown may indicate that the boy who saw less of his father may take a longer time to express his grief than his mother who saw more. The use of the present tense in referring to wheels on the refrigerator raises the possibility that Jane separated herself from James item by item. Her tendency to think "Oh, he'll be back" even though she accepts that "he won't be coming home" may be related to James' attitude to himself, viz., that he had a future, that he was not going to die. Financial security is still a real and legitimate concern. The tendency to acclaim the virtues and achievements of the deceased and the survivors is more pronounced here than before. Yet with this there is a realization that her identity is changing, that part of her died with her husband.

There are the beginnings of a realistic assessment of the implications of her marital status. It means aloneness, searching for a future without her spouse and perhaps re-marriage. Yet the reality of being a widow, being single, being fearful of her threat to other wives is distasteful. The loss of 30 pounds, double the amount at six weeks of bereavement, indicates continuing psychological upset.

Late Reaction to Bereavement (7-12 months)

In the twelfth interview Jane talked for 45 minutes

on the subject of settling her legal estate. She mentioned setting up a course to help the unexpectedly bereaved to find their way through the maze of government regulations, insurance company procedures and other legal transactions. Following that her body activated, throat muscles tightened, fists clenched and her voice became loud and coarse. Concerns centered around her former male friends of the family who did not now show any affection to her. She interpreted this as a result of their fear of "being misinterpreted." "Who do they think I am? I would never throw myself at them. I have more sense than that!" she answered.

Being referred to as a "single" brought this response: "That really makes me mad." Friends who looked upon her with pity fell under the same shadow of contempt. On the other hand she appreciated friends who teased, flirted and joked with her, just as they had done before.

The conversation then moved across several subjects such as: dreams of drowning with her husband, her improved pattern of sleep, erotic dreams of re-marrying and having feelings of affection for another man. The interview ended with light-hearted laughter.

The thirteenth interview began by Jane relating her distress at having to force herself to do those things which previously came automatically: "Jane, put the kettle on. Now go take a shower!" she commanded herself. She did not yet care whether she lived or died. Theorizing about

her experience she mentioned that the difference between losing an infant or child and losing a spouse, is that the former is a shared experience while the latter is solitary.

She still thought of James as coming home from a business trip but stopped this activity by recalling his body in the casket. Jane appeared at this time to be very physically inactive. She sat without obviously moving her hands, legs or head. She talked about her teen-age daughter who was being non-cooperative in matters of curfew. Some satisfaction was evident as she explained how a student who appeared "sour on life" told the story of his suffering to her and how she related her story to him.

The fourteenth contact with Jane was a phone call from her indicating a trip to the Emergency Department of a local hospital. She had been sedated and released. She explained that she felt that this writer had let her down spiritually. She was not able to clarify for the author what she meant by this statement, although she mentioned that her oldest daughter had reported the author as saying that he did not want her to lean on him but wanted her to stand on her own feet.

The fifteenth interview was a home visit at which her oldest daughter was present. Jane seemed relieved. There was little evidence of hostility toward anyone, including the author. We talked of immortality, of living one day at a time with the strength that comes from God.

At a local committee meeting Jane presented a proposal

for helping those who are suddenly bereaved through the loss of a spouse. She appeared coherent and amiable and her effort seemed to be appreciated by the group.

Our sixteenth interview took place midway in this 7-12 month period. Jane suffered from recurring spinal problems. She talked a lot about her husband in relation to how former employees felt about him. Although her previous comments about him were very flattering she revealed "I wouldn't work for him. It would have ruined our marriage." She followed that with several minutes of idealizing herself. For example: "I was very special to my parents." And later on: "Even the parents of the boys I went with thought I was special."

As this interview progressed she seemed to forget about her sore back. Her body became more animated while her face lost its pained expression. Jane talked about a summer vacation which she had planned and about several vocational options she was exploring. She wondered if she would ever become her "same old stuff" again.

During the seventeenth interview, midway through the last quarter, she revealed a general disenchantment with friends, doctors, and ministers. She had gone to another minister who was "more helpful" than the author had been. He talked to her about her faith whereas she reported that the writer had neglected doing this. She had talked with a medium, a former acquaintance, who reported that James told her to tell Jane not to worry about him.

Toward the end of the twelfth month, during a brief encounter, she appeared to be cheerful. She talked about her past and joked and laughed. She did not reveal any dissatisfaction with friends, her doctor or her minister. She complained about a relative who had not met one of her expectations but gave her the benefit of the doubt, explaining her action by estimating that she had not been raised the way her children had so that she could not be expected to behave accordingly.

Near the end of the first year Jane wrote me a letter which clearly painted a picture of her internal state and her awareness of it. Following are a number of excerpts from it:

My doctor put his finger on it right from the start, because of the type of job that James had he said I would find it easier at the start than a woman who had her man coming home every night at 5 o'clock but that it would hit me pretty hard later when reality set in.

Referring to a comment the author had made to her oldest daughter about not allowing Jane to become overly dependent on him, she wrote:

I was sort of hurt when _____ told me that you weren't going to let me lean on you too much. The rational part of me reasoned why you were doing this but the irrational that is in all of us was hurt at what I thought was your lack of confidence in me.

The struggle to meet the expectations of others was apparent in the illuminating remarks:

One thing you did say to me to make me feel guilty was that whereas I had noticed a change in some people . . . you told me that some people had

noticed a change in me. I knew this to be true and felt very badly about it and would have given the world if I could have been the old Jane. As a matter of fact this is what led in part to my breakdown for I was acting a part. I could almost taste the desire in my friends for me to be happy again so I put on an act and that is all it was, a big sham, I was totally empty inside.

The next part of her letter was most revealing, relative to pointing out what helped her escape from the box of pretending to be happy:

George (another minister she called) relieved me of that burden, without any of the knowledge of our conversations, by telling me that I would never be the same again. He didn't infer that I would never be happy again but that an experience such as I had had would leave me different in some respects.

Jane's belief in an after-life appeared to be of comfort and a source of hope: "I know there will be lonely times and maybe setbacks but I'm sure that none will be as serious, because I've accepted the fact that James has just moved on and that sometime I will see him again."

In a conversation occurring 3 months beyond the time of this study Jane reported to me her advice to a woman friend whose neighbor of the same age was dying from a terminal illness. Her friend planned to see a psychiatrist to get some relief from the anxiety her neighbor's imminent death was triggering in her. Jane counselled her in the following way: "You don't need a psychiatrist. What you need is some faith. I'll give you Catharine Marshall's book To Live Again. Read it!"

The last interview to be recorded occurred at the middle of the thirteenth month. It is reported here because

of its possible significance. Jane had just returned from a holiday during which she visited her own and her husband's relatives. She related the funny things that happened. She laughed a lot. However, she recalled visiting James' cousin who reminded her of her husband. "I watched his hands. They were similar to James'. I felt revolted."

She was due to start a new job the next day. She assessed her preparedness for it in this way: "A year ago I couldn't have considered it. Now I'm not worried. I just want to get something that I can give myself to completely so that I can look forward to Monday morning rather than dreading it."

She appeared as strong as her words suggested. At that moment the phone rang and her son answered it. The caller hung up. She reported that it was probably the mysterious voice who had already called her several times. His strategy was to say her name and then break into prolonged sobbing. This incident did not seem to unduly upset her.

Conclusions

At the beginning of the seventh month period feelings of helplessness which were centered on the estate settlement were experienced. A verbal indication of wanting to do something for others was offered but was not followed through into any action at that point in time. Hostility focussing on family friends was expressed verbally and

through body language such as tightness, clenched fists' and a voice that became loud and coarse.

Jane was aware of her lack of spontaneity and of her having to force herself to do routine tasks. At the same time (eighth month) she began to theorize about her experience in terms of the death of a child compared to the death of a spouse. She continued to imagine that James would be home one day, although this activity was effectively arrested by recalling the memory of his coffin.

Toward the end of the ninth month hostility was transferred to the author. Yet when it was accepted rather than reacted to it dissipated. At the end of the ninth month Jane channelled some of her energy into creativity by outlining and presenting a proposal of a scheme for helping the unexpectedly bereaved.

The last two or three months was marked with the recurrence of back trouble. Unprovoked anger was experienced. Jane still idealized the deceased although she admitted to being unwilling to work for him full-time. She seemed to exaggerate her status with her parents and the parents of her former boy friends. In this way perhaps she comforted and stroked herself.

There was a tendency for her to wind down toward the end of the interview and for the duration of the interview to be shorter. The degree of bitterness formerly felt toward friends and life in general had lessened.

Her judgment seemed to be more informed by her reason

than heretofore. She appeared to be aware of the rational and irrational components in her assessment of others' behaviour.

She indicated that her belief in an after-life seemed to have significance for her in terms of changing the degree or quality of her loneliness. Her conviction that such a belief was helpful in reducing upset and anxiety resulting from bereavement revealed itself again in her advice to her friend not to go to a psychiatrist but to get some faith.

In the final interview, occurring in the thirteenth month, she appeared in good spirits. She indicated further acceptance of James' death and separation of herself from him. Although due to start a new job she felt definitely self-confident and energetic. Even the nuisance phone call of a deranged male did not appear to disturb her unduly.

Case Study Two

Census and Personal Data of the Deceased

Jack B. was a middle-aged husband and father of two boys. An executive, he was employed at the supervisory level by a company for which he had been working for 25 years. His father, mother, and two sisters were still alive at the time of his demise. Because he was a sickly child his mother had given him to his grandmother who raised him until he was 14 years old.

Jack received major surgery 15 years ago and since

then had suffered two coronary attacks although these were never medically confirmed. He was fond of outdoor recreation such as fishing and camping activities in which all his family participated. He died in his own bed from a coronary attack. Jack and Mabel had been married for over 25 years.

Census and Personal Data of the Survivors

Jack's family consisted of his wife, Mabel, and two sons, Trevor and David, both in their 20's. Mabel's mother was alive but her father had died one year before. She was one of two children. Mabel's life was largely determined by Jack's work schedule, the state of his health and the needs of her sons. Both boys lived at home and appeared to be still dependent upon their parents to meet their housing and social needs.

While this family of four seemed fairly compatible, the boys communicated more with Jack than with Mabel. Jack appeared to be more patient with them. Each evening prior to supper all four gathered for a drink or two. On the weekends they usually went somewhere together. Their conversation was apparently about things, places, people, and events. No mention was made of Jack's possible death because Mabel was frightened of the meanings death held for her. As a result Jack and the boys avoided the subject. Fearing that Mabel would be emotionally unable to cope with his death, Jack had arranged to have a Trust Company handle his estate.

Immediate Reaction to Bereavement (1-30 days)

On the first call at the home, Mabel, Trevor and David appeared composed. There were no tears shed. The story of Jack's death was told. Funeral details were discussed in a business-like manner. Mabel's tongue seemed thick and her mouth noticeably dry. Each of the three seemed to share the sentiment that Jack had suffered enough throughout his life and that for him death was a release.

On the second interview Mabel was alone, the relatives and friends having returned home. She mentioned that the funeral ceremony suited her husband and that her relatives and neighbors had been a great support to her. As yet she had not realized any change in her life. Thus she had mistakenly set a place at the breakfast table for her husband and was aware of something she wanted to tell him when he came home that evening. She had missed him when he did not come home from work at 5 p.m. the day following his death.

She was concerned about not crying as yet. Although she reported getting a prescription from the doctor at the Emergency Department of the hospital at which Jack was pronounced dead, she had not taken any. Mabel wondered about the normality of her lack of tears. She appeared relieved when assured that she would get to her tears in her own time.

Other concerns such as not having a will of her

own and being unable to find a key to the safety deposit box demanded her attention. She worried about David who had upset his father by quitting his job. This occurred the day before Jack's death. Finding notes of the nature of a diary made by Jack caused Mabel to ask herself if she ever really knew him. A re-examination of her relationship to him and of their relationship to the children followed. She indicated that nothing Jack or anyone else might have done could have changed the outcome for "when your time has come it has come."

During the third house call Mabel expressed her frustration at the slowness of the Trust Company which is the executor of Jack's estate. She was surprised at her own ability to cope with matters successfully: "You never know [what you can do] until you are faced with it," she indicated. Sometimes it seemed to her that Jack had been gone for years. At other times it seemed that he had been gone only a day. She had continued to miss him more at 5 p.m. than at any other time of day, yet she commented, "Even that is not as bad as it was."

Mabel guessed that Jack knew he was going to die from the way he saved money in the last several years and his comments to her after he had drunk several bottles of beer. She was not aware of any feasible options Jack had beside the one he chose, viz., to stay at the same occupation. Again, she firmly reiterated, "The day you're born your days are numbered, and there's nothing you can do about it."

She appeared angry as she reported on Jack's tendency to feel happy, free, and a desire to communicate with her only after an evening of continued drinking. "This made me mad! Why couldn't he be that way without it?" Evidently Mabel had often expressed anger to Jack by withdrawal, e.g., she would refuse to say good-bye to him before he left for work. While she regretted her past behaviour she still showed some resentment that Jack would not fight with her. It made her feel like a nag.

The conversation continued as Mabel lamented not having any religious beliefs in common with Jack. "We were married ten years before I found out he did not believe in God. I was shocked," she said. Again, her concern about grieving appropriately emerged: "I don't know what's wrong with me but I haven't broken down. Is there something wrong with me? Oh I have cried. But is that enough? I hope people don't think I'm odd. David hasn't broken down either."

For three weeks she did not leave the house because she felt safe there. Yet after her first outing she felt good to get away and good to return home. While she still maintained her routine of rising at 5:45 a.m. she did not work as hard as before. She complained, "Now I look at it in a pile and I can't bring myself to touch it." She mentioned that she had not told to her neighbors what she had told to me because she was afraid that they might break confidentiality.

Conclusions

The reality of Jack's death was not comprehended by Mabel at first. The fact of his death did not prevent her from setting a place for him at the breakfast table or saving up things to tell him at night when he arrived home. From the beginning she was concerned about not grieving appropriately. A mental search for the cause of Jack's death was evident. David may have linked his resignation from his job as the cause. Mabel attributed the cause to fate. The question of how well she knew her husband and the nature of their family relationships surfaced.

Mabel surprised herself by coping with business transactions previously looked after solely by Jack. Perhaps there was a sense of new-found achievement there as well. She was aware of missing him at the time of day they usually shared, namely, about 5 p.m. A loss of a sense of time passing was experienced. Mabel appeared comforted by the belief that Jack's life was limited by fate and that nothing he or she might have done would have made any difference. She was aware of, and expressed easily, her resentment concerning his need to drink excessively before he felt free enough to communicate with her. As well, she resented Jack's refusal to argue with her. Mabel seemed to regret her own use of the same strategy toward him.

Considerable concern was expressed about the importance of grieving in the acceptable manner. While there seemed

to be a need to comply with others' assumed expectations, Mabel's own internal state did not cooperate. Thus she did not match the typical picture of the widow completely overwhelmed in her grief. A lack of motivation to do previously meaningful tasks was experienced. She seemed to have a need to articulate her thoughts and feelings with the assurance that confidentiality would be respected.

Early Reaction to Bereavement (2-6 months)

The fourth contact with the B. family was with 22 year old David. It is mentioned here because of its affect on Mabel. She was increasingly concerned about David. After persuasion by his mother David agreed to talk his situation over with the writer. During the interview David revealed that he had felt guilty about being a disappointment to his dad because he had not finished his formal education. He did not believe that his quitting his job precipitated his father's death. "I think his job killed him. But I couldn't do anything about that," he said. Following the interview he obtained full-time employment (which he has maintained for more than one year).

During the fifth pastoral contact the author found Mabel anxious to settle the estate. She wanted to do something as a volunteer but found objections to several possibilities presented to her. She reported that she had lost her purpose in living. Elaborating, she indicated that Jack had had a poor home life as a child. Mabel had tried to compensate for this past inadequacy. She had

"babied" him. Severe abdominal surgery 20 years ago had necessitated his eating five meals a day. Caring for him had given her a sense of purpose. His death evaporated this sense of purpose.

Because of a crisis with her sons, partially referred to above, she began to examine the nature of her relationship with them and to compare it with the kind of relationship Jack had. She confessed to admiring the way he made certain decisions for he often would think for an hour and then give his answer. On the other hand, she acted impulsively. A change in her way of relating was being considered. She thought that if she treated her sons more as adults, they might respond to her with more adult behaviour. Mention was made of lack of intimacy between mother and sons for which the father had compensated by sharing certain recreational activities such as hunting. His demise clarified the lack of closeness between mother and sons. Mabel looked at options for bridging the gap.

Toward the end of our conversation Mabel concluded that she and Jack had "talked about a lot of things." This surprised her, for she heretofore thought that they discussed but little with each other. She became aware that Jack's surgery and probable coronary attacks had caused her to "steel" herself for his death.

On the sixth pastoral call Mabel looked very tired. She complained about missing Jack on a particular Saturday and during a party she hosted at home. Jack usually had

served the beverage. Mabel had tried to do this but reported, "I made a mess of it. I never realized how much I depended on him. I took him for granted." She had no desire to go out anywhere and was confused by her own reaction to bereavement as her words indicate:

I don't know what's wrong with me. When my father died--and he was senile for a long time--I really cried. When Jack died, I didn't. The first time I saw him in the coffin I said to one of the men [a colleague] that I wouldn't want him back. He didn't understand why I would say that. I guess I said the wrong thing. But they didn't know how sick he had been. I did. He wouldn't let on to them. But I knew even though he didn't complain.

At our seventh interview Mabel starting talking at an unusually high speed as soon as we sat down. Up until Jack's death she had handled unpleasant experiences by wishing herself a year ahead. "I've wished my whole life away," she concluded. This method had not succeeded in helping her get away from the discomfort of bereavement. Consequently she intended changing her life-style, as indicated by her words: "I guess I'm going to have to start living a day at a time."

Mabel then recounted several reports of appearances of the deceased. Her brother, awakening from sleep, saw Jack standing before him. Her neighbor reported a visit from him during the funeral held in his memory. Her oldest son saw him standing in the room with him at his place of employment. These reports did not appear to disturb her. She accounted for them on the basis of imagination. Mabel mentioned that she was aware of

missing Jack more as time passed. This was especially so on Saturday, the day he customarily spent around the home. She felt alone. This feeling was expressed even when she was with a group of friends.

She seemed upset about her inability to sleep. She averaged three hours per night. In an attempt to avoid needing sleeping pills she worked hard physically around the house so as to produce tiredness. She continued to awaken at two o'clock in the morning anyway. Volunteering that she was feeling sorry for herself she related the story of a woman who shared her own life situation. After that she concluded, "I felt I haven't got it so bad after all." Reporting that she found herself looking at old couples she stated that she realized that this would never happen to her and Jack. She seemed surprised as though she had never thought of that before.

Toward the end of this call Mabel expressed her growing awareness of the nature of her relationship with her sons. She wanted them to be independent of her, yet she desired their dependence and company--especially for the last six months. Recalling the way in which she handled her anger, by becoming silent for one or two days, she expressed relief that she had not been doing that to him the night before he died. Indicating that she talked to no one about the above concerns, she added, "I really appreciate being able to talk to somebody."

In a follow-up interview with David, it was learned

that his work pattern had stabilized and that he had resumed a correspondence course. He appeared in good spirits. He seemed relieved that his father did not have to suffer any more:

Author: How is it with you not having your dad?

David: It's funny you know, but I'm relieved that he's gone. That he doesn't have to live through things like the energy crisis. He had suffered enough. I wouldn't want him back. No sir.

Author: He suffered quite a bit?

David: Nobody knew how much and he was the kind of a guy who couldn't back off a job.

Conclusions

The death of the father was the cause of David's increasing feeling of responsibility toward his mother. As she had, he too looked for the cause of his father's demise. Although admitting to some guilt feelings around quitting his job and his father's resulting disappointment, David saw the cause of death as inevitable consequence of his father's poor health and the pressure of employment. He indicated a tendency to imitate his father's work pattern--a tendency noticeably absent until this point in time: "I want to get a job and keep it," he said.

Mabel seemed unsettled. This seemed partially related to the unsettled condition of her legal estate. This appeared in her mind to be the pre-requisite for making other decisions. She was aware of a loss of purpose for herself. For the first time an appreciation of her

husband's method of decision-making developed. Along with that came a re-evaluation of her own way of relating to her sons. She admitted to preparing herself over the years for Jack's death, as a result of his previous surgery and coronaries.

A deepening sense of loss and the finality of death developed around the Christmas event. She became acutely aware of her aloneness when she entertained guests and was forced to perform some of the tasks which Jack had done. In addition to the loss of a spouse she was becoming aware of a loss of some of her identity. Therefore she felt too inadequate to cope socially and found being alone more comfortable than being with others. This was especially true for social settings which she and Jack had frequented together.

Comparing her response to her father's death for which she had really cried to her reaction to her husband's death caused her to wonder about her love for Jack. This was accentuated by her own sense of relief that Jack did not have to suffer anymore. The result was a sense of guilt--although she realized that this was irrational.

An examination of her coping mechanisms and a revision of them occurred toward the end of this period. She decided to live a day at a time rather than wishing herself into the future to avoid unpleasantness in the present. Reports of several post mortem appearances of her spouse did not seem to alarm her. Feelings of aloneness were

heightened on Saturday, the day she and Jack customarily spent together. Tiredness from lack of sleep was a continuing concern. She averaged about three hours sleep per night. Even hard physical activity throughout the day did not alter this pattern.

Mabel gained some comfort from hearing the plight of another who was coping with greater struggles than she. Some of her concerns such as future aloneness and her changing relationship with her sons were still with her though by her own admission at a deepened level of awareness. Feelings of guilt regarding expressing her anger toward Jack by remaining silent for several days surfaced. Along with this was a sense of relief that she was not involved in this activity the night before he died. The value of sharing her feelings with someone was recognized by her for the first time.

David, in two months, had by then regained steady employment, evidenced little feeling of grief, and resumed an unfinished high school program. Although he appeared to over-idealize his father's employment potential, he expressed relief that his father had no more suffering with which to contend.

Late Reaction to Bereavement (7-12 months)

During the eighth interview Mabel reported being upset because she had just returned from witnessing the place where her husband's ashes had been spread. Her husband's father had been buried the day before the

interview and pressure had been brought by his family to go and make the funeral arrangements, as Jack would have done. "Should I have gone? I think I should have, but I didn't want to," she said.

She indicated that she felt guilty about the size of her estate: "What was the point of all his hard work? He worked all those years and for what?" She felt guilty about turning down a request from Jack's sister, even though it had been his custom to come to her aid. Although she admitted to feeling less lonely and being glad that her two sons were living at home, she was faced with making several decisions, the outcome of which might necessitate their moving away from home. She had decided to set down some house rules regarding their drinking and their tendency to stay out late. She feared they might leave if she enforced such rules. Yet their habits were the cause of considerable distress. One of the most positive activities she had engaged in were ladies keep-fit classes, which she reported "made the winter go so fast."

For the final interview, occurring about twelve months following bereavement, Mabel appeared more relaxed than the author had witnessed her up to that point. She had asked her sons to leave and they had subsequently found their own accommodation. They were faring quite well. She reported "I'm really surprised." Although she was somewhat afraid of being alone at night, she indicated, "I'm at peace. I have more peace now than I have known in

years . . . there is no illness to worry about and no waking up to the turning of the key in the door in the middle of the night."

Her estate had been finalized and she was working one day a week as a volunteer in an Auxilary Hospital. She commented, "I really like it."

With regard to her handling of her grief she commented, "I'm doing fine--although I don't think others think so. They think there is something wrong with me . . . I haven't cried in public. I just get busy with something. I force myself." She had continued with a mixed social club she and Jack had belonged to for several years. She was glad she had not stopped it and reported that she appreciated mixing with men. She had gone out to one party and felt out of place.

Saturday was still the most difficult day for her. She elaborated the activities which she and Jack had shared on that day over the years. They included shopping and going for lunch together. "He just wanted me to be there with him," she concluded.

Looking back, Mabel indicated she had kept up a feverish pace until July (the tenth month following bereavement). By then she felt so tired she sat around all summer. "I really enjoyed the summer," she said. Looking ahead, she expressed a need for a challenge. She wondered how one finds a major challenge in life. The interview concluded with her observation: "I don't know

how I would have survived without Someone to believe in."

Conclusions

Difficulty was experienced because the expectations of Jack's relatives, who, having suffered the loss of the functions formerly performed by the deceased, assumed that Mabel would carry on her husband's role. This presented an unexpected moral dilemma which was resolved on a rational basis, although not without some accompanying guilt. Guilt over being alive to inherit the financial benefit which accrued as a result of the husband's death was experienced as well. Just as agonizing was the struggle to initiate or cease functions at variance with the former behaviour of the deceased, e.g., refusing to aid a relative who made unreasonable demands. This was the case also with respect to Mabel's relationship to her own sons as evidenced by her reluctant decision to limit their drinking while at home and to specify time boundaries relative to arriving home at night.

Clearly she was not as agitated as she had been two months before. Physical activity in the form of keep-fit classes brought her obvious satisfaction.

The decision to ask her sons to find their own accommodation was accompanied by fear of being alone for the first time in her life. Yet her ability to carry through the decision might have indicated that she was at last ready to face one of the significant implications of her bereavement, viz., her aloneness. Further

decisional capacity was exemplified by Mabel's initiative in changing her pattern of care from inside her home to an Auxiliary Hospital setting. She confessed to experiencing greater peace than she had known in years.

There was still a concern that she had not met other people's expectations relative to expressing her grief. While she still enjoyed the mixed social club to which she and Jack had belonged, she was acutely uncomfortable. The feeling of "lostness" continued to be felt most on the one day she and Jack had spent conjointly.

Looking back, she saw her behaviour as being hyperactive for the first nine months of bereavement. This was followed by a period of exhaustion and rest, which in turn was superseded by a return to a more normal routine. Looking ahead, she yearned for a challenge, for some cause to which to give herself. Finally, she indicated that her faith in God (whatever she meant by that) had been a key resource in making possible her survival.

Case Study Three

Census and Personal Data of the Deceased

George C. was a middle-aged husband and father who had worked as a professional teacher for the past ten years. George was informed of a shadow on his lung in April. Since he was carrying a heavy work load, he decided to wait until the end of June to see a doctor. The June visit to a doctor was followed immediately by surgery for the removal of a malignant tumour. In August another surgical

attempt was made to remove a malignant growth. Therapy continued until October, at which time George resumed his work. He continued working until early May when he was hospitalized for further treatment. He died in late May while undergoing treatment. Although the author had visited him a dozen times since the onset of his illness, George was not very articulate concerning his own inner state. He was reluctant to discuss the implications of his illness which seemed from the onset to have several of the components of a terminal disease. Many times he repeated to the writer, "I have to beat this (illness) and that is all there is to it." This continued to be his stance until he lapsed into unconsciousness.

Census and Personal Data of the Survivors

Mary C. was a homemaker for her three boys in elementary school. She was in her thirties and had been married to George for 15 years. Although small and frail in appearance, she had enjoyed good health all her life. Mary was pregnant in June when George received his first operation. A baby girl was born the following January, giving them four children in all.

Mary's parents and brothers (both in their 40's) lived on the home farm not far from the city. In the past she and George and the children had spent at least a few hours every week with her parents and brothers. They maintained a garden on the home farm and related to her relatives in a mutually supportive way.

In addition to having a close relationship to her brothers and parents, Mary related well and spent time with George's two sisters who lived in the same subdivision. They liked to baby-sit and to help Mary with the children whenever Mary or George were ill or overly busy.

Following her husband's first visit to the doctor, Mary was visited by the doctor and received an assessment of the implications of George's condition. The doctor was not optimistic and clearly indicated his concern to her. From June until George's death the following May, the author visited Mary at home or talked with her by phone a dozen times. She was under great stress, as evidenced by an increasing hyperactivity, noticeable body movements of a nervous nature such as unsteady hands, exaggerated arm motion, the loss of a modulated speaking voice. Many others who had known her and worked with her commented on these changes. Throughout the year of George's illness, Mary's dominant concern seemed to be the fear that his treatments would not be successful. This continued until the very day of George's death. Although the writer presented the opportunity of discussing the probable implications of her husband's illness, Mary never spoke of this possibility. She revealed that she and George had never talked about the possibility of his premature death.

Immediate Reaction to Bereavement (1-30 days)

On the day of George's death, Mary's prime concern

seemed to be how to tell the children. The author was asked to help in this task. Mary did not appear to have been surprised by the death, nor did she seem acutely grief-stricken. The conversation in the first day of bereavement was about funeral arrangements and whether to take the children to the funeral or to leave them with a sitter. During the funeral and graveside ceremonies Mary functioned quite well, displaying no tears at any point.

Through the first month she busied herself in settling the estate. Her conversations were directed to such areas as pensions, probating a will and the questions the children were asking as to their father's location. She reported having an accident with the family car. She was obviously relieved when the car was repaired.

By the end of the first month she had used her own former business training and settled her husband's estate. There were still areas of unfinished business but they did not appear to concern her. She had completed enough transactions so as to be able to estimate her approximate income. This was understandably of importance to her. Having done this she had decided that there would be no financial reasons for her to seek employment beyond her own house. Mary appeared to be very concerned to have a good garden. She organized her week so as to spend about one full day working in the garden. Her energies were focussed on securing children's programs for her family for

the two months of summer holidays just ahead. She indicated that the children had become very demanding and that she was attempting to meet their demands.

Conclusions

In the first month of bereavement Mary's behaviour did not appear to change drastically from before her husband's demise. She faced the decisions regarding the funeral, settling the estate and fixing the car in an almost business-like manner. There was no obvious display of emotion in the writer's presence. She did not seem to realize George's death had occurred. Whereas during George's illness much of her energy had gone into caring for him and being concerned about him, she had by now switched her energy into the demanding task of settling the estate, working in her garden and caring for her family and home.

The accident with the family car caused an inordinate amount of anxiety. Similarly, the relief she experienced and expressed at having the repair completed satisfactorily, might indicate that the car had special significance to her. By the end of the first month she appeared more hyperactive and nervous than before. Excessive activity, partly resulting from attempting to meet her children's demands, was noticeable. It appeared that their verbal wishes had gained the status of adult commands to Mary. When this subject was approached, she viewed the children's requests and her own response as inevitable.

Early Reaction to Bereavement (2-6 months)

During the fourth pastoral call since the onset of bereavement Mary reported on the progress of her garden and discussed the necessity of various repairs to the exterior of the house prior to winter. She mentioned feeling sorry for her children because without a father they would be unable to go to such places and do the things their father used to do with them. She indicated that she had begun playing with the children prior to bedtime, just as her husband had customarily done prior to his illness. Following their bedtime she worked until one o'clock in the morning doing her own work.

Mary revealed that during George's illness she had had a series of dreams of walking alone. She had connected her aloneness in the dreams with her fear of being a widow. She had not discussed her dreams with anyone before. The discussion on her dreams was concluded by her remark, "Oh well, it's happened. I can't do anything about it."

Regarding changes in her social life, she reported that she did not go anywhere that she and George had frequented together. She continued to visit a neighbor, but only when her husband was not home. She seemed cautious about invading their marital privacy. Mary wanted to go to an imminent banquet but the dance following the banquet seemed to give her a reason for not going to either. However, she expressed interest as to whether or

not another recently-widowed woman would go.

As to her internal state she commented, "I just feel empty inside. All the time. I've got the children. But it's just this emptiness." It was worse for her on Friday nights and weekends than on the other days. Mary indicated what continued to be of concern to her, namely, the inner frustration of being unable to repair household fixtures which George had previously fixed. When it was suggested that other men of mutual acquaintance were willing to assist her, she closed this concern with the remark, "But other men have their own lives."

Our fifth visit, occurring toward the end of this period, found Mary ill. She had lost weight. In her concern to keep the house in good repair she had completely painted its interior. She reported maintaining her schedule of working 18 hours a day. Even with that work load, she was unable to sleep properly.

She was concerned about the oldest boy who had begun having asthmatic attacks. He had no previous history of this kind of trouble. Of all of the children, he mentioned his father's death more than the others. Mary seemed more concerned about her children's bereavement than her own. To the question, "Do you miss George?" she replied, "Yes, we all miss him. I don't worry as much about me as about the children missing him."

Mary had not yet been out socially to mixed events. She indicated that she wanted to go to some of the events

that she and George had gone to before, but was afraid that she might break down and cry. For the first time (almost 6 months from the beginning of bereavement) she indicated that she was able to cry, but that she cried alone and away from the children, especially, so as to avoid reminding them of their loss.

She reported that she had had to force herself to eat and that the doctor had prescribed a tonic to increase her appetite. She had become aware that she had been trying to make up to the children for the loss of their father by being both mother and father to them. However, she concluded, "I can't, I just can't. I don't have the energy." Mary expressed concern about being on what she referred to as "nerve pills," prescribed by her doctor at some point in the six months following her husband's death. She appeared to get some comfort, hope even, from acknowledging that other people had found themselves in situations similar to her own: "Well others have gone through it. That's the only comfort I have. They made it. Maybe so can I."

Conclusions

By the beginning of the second month Mary did not appear as hyperactive or exhibit some of her nervous movements to the same degree as before. She seemed to be going through a role change as she contemplated the needed external repairs to the house. In addition to being a mother, she was taking over some of the tasks traditionally

accepted by the husband and father. Thus she took time to play with the children before bedtime, took them fishing and to drive-in theatres, and at the same time attempted to continue all the activities regarded as belonging to the mother, such as sewing and preserving garden vegetables. These increased activities necessitated her working 18 hours a day.

It was evident that Mary had entertained the possibility during George's illness of becoming a widow but that she had not shared that fear until that particular interview. She was aware of the reality of her spouse's death and of her helplessness to change that reality.

Mary's social life had changed as a direct result of George's death. She was cautious about mixing with other couples, feeling that she was an unwelcome invader of their privacy. Activities which required the involvement of men and women together made her so uncomfortable she avoided them. Thus, from her point of view, she could enjoy a banquet but not a dance. She might consider going to a banquet and dance if another widow decided to go. It appeared that Mary, while admittedly suffering from the social awkwardness that the loss of a spouse might induce, was looking for someone to model, someone she could follow in adopting proper social etiquette for widows.

The emptiness complained about was accentuated during the periods which George had spent at home with Mary and the children. The frustration which resulted

from not being able to fulfill the household-repair function of her husband was increased because of Mary's reluctance to ask other willing neighborhood men to assist her on the grounds that this constituted an invasion of privacy. It appeared that with widowhood Mary accepted some form of social ostracization which separated her from resources of married couples. She saw herself sitting outside the mainstream of "normal" families.

By the end of the two to six month period Mary had lost weight. She had been to her doctor and was on a tonic for increasing her appetite and a tranquilizing medication for slowing her down. Although she felt exhausted, she was unable to sleep properly. The oldest boy had developed asthmatic attacks which Mary linked with the loss of his father. She had come to the realization that she could not perform the functions previously performed by father because she did not have the time and energy.

Mary reported that she cried often but did so privately in order to protect her children from having to cope with her feelings of loss and helplessness. Although admitting that the medication she was taking was helpful to her, she was worried that she might become too dependent upon it. The fact that her circumstances were not unique, that others had coped with a similar situation, seemed to give her cause for comfort and hope.

Late Reaction to Bereavement (7-12 months)

During our sixth visit Mary seemed very concerned about the final settlement of her estate. She was waiting to receive one item of information which would enable her to know her exact income. She indicated that she regretted not being able to attend a mixed social function which consisted of former acquaintances of both George and herself. She had taken ill prior to it. A wish was expressed to be able to do many of the minor house and car repairs previously done by her husband.

On the seventh pastoral call Mary appeared tired. She indicated some frustration at not being able to "keep up." She mentioned that she was switching her two oldest boys from a Cub Pack led by a woman to one led by a man. "They need male influence," she said. She related that she was taking her boys tobogganning and skating, just as her husband had done. When the author suggested that her children were being offered more recreational activities than were the majority of children, she seemed pleased. When the author further suggested that she might be offering her children more than they needed, at the expense of her own health, she responded with appreciation as though he had intended a compliment. In actuality, he had intended a note of caution. The conversation moved to prioritizing her work load so as to delay some tasks which allow her more time and energy in the present while at the same time not jeopardizing her efforts to care for

her home and children at a standard acceptable to herself. Evidently the oldest boy had begun to suck his thumb. "He's sucking his thumb again, and he's ten years old," she indicated. We talked about the possible reasons for this. She suspected that he was somehow responding to her anxiety.

During the eighth interview, occurring one year following bereavement, Mary, appearing healthier than before, did not seem as agitated as in the first six months. Her physical movements were slower and seemed more co-ordinated. She talked about the possible causes of her husband's death. She was still attempting to locate a specific reason for his cancer. "I wonder if it was one of those insecticides or something? He used that stuff for years," she said.

A concern about having enough income was voiced by her. Mary indicated a desire to take her children on an auto trip to another city but expressed anxiety about the reliability of her auto to make the trip successfully. She was still worried about her oldest child only this time she focussed on his lack of interest in sports and in other boys his own age. She revealed that her husband had befriended the boy to the extent that he had made neither school nor neighborhood friends. Thus his recreational activities had not involved his own peer group even before his father died.

The interview closed with Mary indicating that she

had attended and enjoyed a mixed social gathering which included adult family members and friends. When she talked about her husband having been dead for one year, her face flushed and her lower lip quivered. However, no tears were shed.

Conclusions

During this period concern over the settlement of her husband's estate continued to play an important part in her life. However, by the twelfth month this concern had diminished considerably. Having been trained as a legal secretary, she had done most of the legal work herself. Although she felt the need of being with other adults she also seemed reluctant to take any initiative or to make a positive response to an invitation. Either from necessity or from inner psychological need, she felt a desire to assume many of the functions previously performed by George. These included house repairs, car repairs, and the assembling of outside Christmas decorations and shovelling the snow. She experienced considerable frustration at not having the energy or the skill to assume this role to her own satisfaction.

The desire to compensate to her children for the loss of their father was especially noticeable in the area of the children's recreation. Mary had taken them skating and tobogganing just as their father had done before his death. Although she was cognitively aware of her own fatigue, executing these activities brought obvious

emotional satisfaction. Her concern to fill the gap of male influence in their lives led her to switch the boys from a Cub group led by a woman to another led by a man. Her major concern appeared to be keeping life the same for her children. To accomplish this she had adopted the functions of her deceased husband. The thrust of her energy went into meeting her children's needs in view of the loss of their father rather than concentrating on fulfilling her own needs in view of the loss of her husband. Thus the return to thumb-sucking by her ten year old boy was upsetting to her. She interpreted this habit as an anxiety response to her own inner state and by implication, a sign that she had somehow let them down.

By the end of the first year of bereavement Mary appeared healthier than before. Her physical movements had slowed noticeably. They seemed more co-ordinated. For example, when she lit a cigarette in the first six months, her hand and arm movements were exaggerated. By now they appeared normal. She wondered and speculated about the physical causes of the cancer which killed George. She was able to look at the nature of her husband's relationship to their children, especially the eldest. Thus she determined that at least part of the reason the boy had no school or neighborhood friends was because George had attempted to be his friend and to play with him after school and on weekends.

She reported that she had recently attended a mixed

social gathering of adults and enjoyed it. The reluctance to be involved with other adults at a social level, evident in the first six months, seemed to have disappeared. When we talked of her husband's death being one year ago, she showed physical signs of upset but managed to control herself. In spite of the opportunity the author gave her to openly express her grief, she declined, as she had done in the year prior to and the year following George's death.

Case Study Four

Census and Personal Data of the Deceased

Beth was a pretty pre-schooler who had a younger sister, Barbara. She lived with her parents Bill and Rene D. in an apartment. Both her maternal and paternal grandparents lived in the same city, which allowed both she and her sister to spend a lot of time with them. The author was acquainted with Beth and her parents, having baptized Beth when she was several months old. Because Bill and Rene each secured extra evening employment for a two-week summer period, Beth stayed with her maternal grandparents, Mr. and Mrs. W. Early one evening Mrs. W. took Beth and Barbara for a walk. While crossing at the cross-walk, Beth was struck and killed immediately by a car whose driver was impaired. Mrs. W. and Barbara narrowly escaped injury or death.

Census and Personal History of the Survivors

While Beth's immediate survivors were her sister, Barbara, and her parents, Rene and Bill, her maternal and

paternal grandparents were also included in the close circle of her mourners. Because Bill and Rene lived in geographical proximity to the grandparents, because the grandparents were keenly interested in the children, and because they all related as an extended family, inclusion of the grandparents in this study was indicated.

Unfortunately, it became impossible to follow up with Mr. and Mrs. W. (the maternal grandparents) because they were retired and spent much of the time out of the city. Mr. and Mrs. D., the paternal grandparents, were retired as well, but were more available. Thus it was decided to include Beth's parents, her sister, and her paternal grandparents in the case study.

Bill D. was a healthy and amiable man. He appeared well-groomed. Although in his mid-twenties, he was unsettled vocationally. At that time he was employed in a full-time job during the day as well as part-time employment at night. He seemed to have a good relationship to his wife, children, parents and in-laws. When notified of Beth's accident he went to the hospital with Rene and was informed that Beth had died. The doctor in charge supplied both Bill and Rene with prescriptions for Valium, which they began taking immediately.

Rene was an attractive, pleasant woman in her mid-twenties, mother of Beth and Barbara and wife of Bill, to whom she had been married for five years. She did not appear to have any major difficulties with her children,

husband, parents or in-laws. She spent most of her time in their apartment with the children except for sporadic part-time evening employment. She maintained close contact with her own and Bill's parents.

Mr. and Mrs. D. had been retired for several years. They both enjoyed good health. Beth and Barbara were their only grandchildren. They usually had one or both of them at their home for a day a week.

Immediate Reaction to Bereavement (1-30 days)

Beth had been killed in the early evening. Bill and Rene met the author in his office the next morning. They reiterated the details of the accident and the events which concluded with the doctor at the hospital telling them Beth had died. Both indicated that her death was still "unreal" to them. "Funny, we don't feel anything," Bill said. "Everybody else cries. We keep comforting them. I don't know. Maybe something is wrong with us." Rene and Bill then mentioned that they had not seen Beth very much for the past two weeks and suggested that this might account for not feeling her absence.

They reported that the biggest difficulty they were experiencing was answering Barbara's questions as to Beth's whereabouts. "We don't know what to say. What should we tell her?" they asked. They expressed concern that Barbara might forget all about Beth through time, and they felt compelled to somehow prevent this from happening. They appeared to be worried about the effect of Beth's

death on her playmates.

They indicated that they were glad that Beth had been baptized. This was followed by speculation focusing on the theme that Beth "was just too good to live." Bill said that he had never known a child as happy as Beth. Prior to her accident she had sommersaulted all the way to the ice-cream parlor. He added, "Guess we'll learn to live with it. Sure glad we have Barbara. If it wasn't for her, I don't know what we would do." Although neither Bill nor Rene hinted about moving, within 24 hours they made a decision to leave their apartment. Bill told his mother, "There is not enough room for kids to play in it."

Both Bill and Rene indicated concern about Beth's paternal grandmother, Mrs. D. They requested that the author call on her. Since Mrs. D. was a parishioner, known to the author, this gesture seemed appropriate. Mrs. D. was alone when visited two days after Beth's death. She reported that she could not believe what had happened. She mentioned that she could not stop crying. As she spoke she began crying again. She seemed pleased as she reported that she had loved Beth more than anything on earth. She added, "They know when you love them . . . and she loved me." Mrs. D. was worried about Mrs. W., Beth's maternal grandmother, who had taken her for a walk when the accident occurred. She appreciated the phone calls and personal visits from friends. "That helped," she commented. "The police were wonderful to Bill and Rene," she added.

Re-focusing the conversation on Beth, Mrs. D. praised her in glowing terms. She showed the author pictures of Beth. Talking through her continuous crying she suggested:

She [Beth] was too good to live. Isn't that an awful thing to say? Somehow I know she was too good to keep . . . I know that we [her husband and herself] are just feeling sorry for ourselves. But we feel cheated. We wanted to see her grow up.

She concluded the call by indicating that Barbara (Beth's younger sister) was a life-saver. "She just acts normal," Mrs. D. reported. At the cemetery, one day later, Mrs. D. insisted on not being supported by anyone. She said to her husband prior to the burial, "I'm all right." Following the burial she commented to the author on the beauty of that place.

Prior to the funeral service Bill and Rene were anxious to make sure that an announcement was made inviting others to return to their home following the ceremony. Following the service they were surrounded by their own friends and friends of their parents. They expressed appreciation to the author for talking about Beth. "It was a wonderful service. That is just the way she was," Rene said. She added that she planned to go away immediately with Barbara and her parents on a two-week vacation. Bill would stay and move their furniture out of the apartment and in the meantime would live with his parents until he found a house to rent.

Toward the end of the first month the author called again on Mrs. D. She reported that she could not make any

sense of Beth's death and that she still could not believe that it had happened. "Everybody is brave in front of everyone else," she said, adding, "I wish someone would break down and have a good bawl." Several days before she had purposely visited a friend in another city. They had spent the whole day talking about Beth's death and its significance for her. "That felt good," she stated with assurance. At some point following that experience she made a decision which she summed in these words: "I just decided that I had to live on." The interview concluded with Mrs. D. expressing concern over her son's (Beth's father) apparent bravery. "He keeps it all inside--like his father. It's not good for him," she said.

Conclusions

The day after Beth's death the episode of her accident and the fact of her death did not seem real to Bill and Rene. They had both been extremely busy and had not seen Beth very often for the previous two weeks. This might have helped prevent the reality of her death from breaking in on them. Because two year old Barbara wanted to know where Beth was they tried to answer her in terms of post-death existence (e.g., Beth has gone to heaven). The author was unable to discern whether or not the belief in an after-life was cognitively and affectively owned by them at that point in time, or whether it was a convenient framework from which to answer their child's questions.

Both Bill and Rene indicated a desire to affirm the

reality of Beth's life prior to the accident through their expressed concern that Barbara not forget her. The words "She was just too good to live" seemed like an attempt to explain why her death occurred. Or perhaps it was an attempt to find some purpose in her death. Both appeared to have an objectivity or at least an aloofness from the impact of their bereavement. An example of this were Bill's words spoken dispassionately. No tears were shed during this first interview. Nor was there any obvious loss of emotional control. There may have been a relationship between their surprising control and the fact that both had received prescriptions for Valium from the doctor immediately subsequent to Beth being pronounced dead at the hospital.

The presence of two year old Barbara was apparently a comfort to them, as indicated by their words: "Sure glad we have Barbara. If it wasn't for her I don't know what we would do." The decision to move from their apartment taken two days following the accident may have been an attempt to avoid unpleasant memories, although the reason offered by Bill was simply that their apartment lacked adequate space in which children could play.

Mrs. D., on the other hand, had been expressing grief since the accident occurred. She was able to articulate the nature of her relationship to Beth. The positive elements in their relationship ("I loved her . . . she loved me.") brought her obvious satisfaction. The support

offered by friends who phoned or called on her was acknowledged and appreciated. Kindness from the police was a source of comfort as well.

Mrs. D. also tried to find some reason for Beth's death ("Somehow I knew she was too good to keep"). She articulated one of the implications of Beth's death, namely, that she and her husband felt cheated because they would never see her mature. She was glad two year old Barbara carried on her usual routine. This fact seemed to provide a factor of stability in the background of an otherwise chaotic experience. Indicating a desire to be independent by insisting that she not be helped to the graveside, she was able to express her appreciation of the beauty of the place following the ceremony.

During and following the funeral Bill and Rene appeared to maintain surprising control of their feelings. They wanted their friends to be with them. Both expressed appreciation of the recognition given to Beth and of their relationship with her in the eulogy. Their last minute plan for Rene to take Barbara and leave on a two-week vacation with her parents might have indicated that she was attempting to avoid facing her own loss. Bill's decision to live with his parents for the next two weeks rather than stay in his apartment may have indicated his need for additional nurture of the type sometimes provided by parents. One wonders if their seeming lack of grief work might be related to the fact that both were taking

a tranquilizing medication.

Near the end of the first month period of bereavement Mrs. D. had difficulty accepting the reality of Beth's death. She reported a conspiracy of pretense amongst the members of Bill and Rene's side of the family. From her point of view everyone seemed to be acting braver than they felt inside. She wished someone would break it up by having a cry in front of the rest. At the same time she indicated that she had made a decision to reinstate her own will to live. Evidently following Beth's death, Mrs. D. had consciously or subconsciously suspended her desire to continue living. A trip to another city for the purpose of talking with a good friend had helped her significantly. She mentioned a special concern for her son Bill, who to her knowledge, had not yet broken down.

Early Reaction to Bereavement (2-6 months)

The fourth visit involved Rene, Mr. and Mrs. D., their daughter, and Beth's sister Barbara about three months following bereavement. Because of vacations and other travels the family had not been available for about two months. Mrs. D. started by acting as the spokesman for the group. With tears in her eyes she indicated that some days she felt okay and on other days something happened to trigger her feelings and "you're off and running." The rest of the family nodded in agreement. She continued, "But my bad days are getting less and less frequent. It's easier now."

Rene reported that everyone (family) talks about Beth all the time. The group laughed when Rene commented that two year old Barbara blamed Beth for hiding her toys when she was unable to locate them. "I'd be upset if we did not talk about her," she went on. As she looked at Beth's picture on the china cabinet there were tears in her eyes. When she mentioned possible legal action against the driver of the car in the accident, her voice became louder and more forceful. Even when her in-laws attempted to interrupt her she kept talking as though she was unaware of them. This call concluded with paternal grandmother announcing that they were going to have another grandchild. She looked pleased at the announcement of this information.

The fifth call involved Rene and Barbara. Rene complained of being grouchy. She discussed her feelings of anger toward her remaining child, her husband, friends, and the landlord. She indicated that this much anger was not normal for her and made her dislike herself. While removing Barbara's coat and boots she showed a considerable amount of irritation which she directed toward Barbara. Referring to Barbara in a joking manner, Rene used words such as "brat," "monster," "devil," and "terror." She recalled that Barbara asked questions as to Beth's whereabouts and present activities and she answered them in terms of "heaven." These answers seemed to satisfy Barbara but not Rene.

Looking back she commented that at the time of Beth's

death she tried to appear strong so that people could talk with her without breaking down, and so that her mother (in whose care Beth was at the time of the accident) would not feel badly. Rene indicated that her mother cried often when by herself but little in the presence of others so that they would not feel sorry for her.

Conclusions

For the paternal grandmother the pain of grief came at increasingly fewer intervals. When it was experienced, it was usually triggered by some external circumstance such as a word or an event. Evidently some of the relatives were, by that point in time, able to talk about their grief in the presence of each other. Rene and the paternal grandparents were able to laugh about Barbara's blaming Beth for hiding her toys. They seemed much more comfortable than before in their acceptance of Beth's death. Rene's report that she wanted to talk about Beth and that silence regarding Beth would be upsetting to her could have indicated a need to affirm the fact that Beth had been alive and that Rene had been a mother to this girl. Rene's anger and aggressiveness which emerged when she discussed legal action against the car driver was directed toward the driver. The grandparents did not reveal these feelings so that it may be that the greater the grief, the greater the anger.

Rene's pregnancy, occurring about one month following Beth's death, might have been an attempt to replace Beth

in her own life and to compensate to the grandparents for losing a grandchild. The looks of satisfaction on everyone's face at the announcement of this news indicated a need was being met or a desire was being fulfilled.

During the call involving only Rene and Barbara (occurring at the end of the fourth month) Rene reported experiencing abnormal amounts of anger (for her) which she directed to her immediate family, friends and landlord. Such feelings were exhibited verbally and non-verbally toward Barbara while the author was present. The absence of obvious symptoms of grief in Rene's case and to what extent this related to her attempt to repress her feelings in front of both sets of grandparents has no easy answer.

Rene's confession that she had remained strong at the time of Beth's death so that others would talk to her without breaking down and so that her mother would not feel bad, seemed plausible. It might also be that in order to protect her mother from an overwhelming sense of guilt, Rene acted as though her grief was not as acute as it really was.

The belief in life-after-death was used to answer Barbara's questions and seemed to be adequate. There was no evidence at that point that such a belief was owned by Rene or any other member of the wider circle of relatives. Although a request to have Barbara baptized was made in that period of time, there was no link between this rite and "life-after-death" articulated.

Late Reaction to Bereavement (7-12 months)

The sixth interview took place in Bill and Rene's suite. Rene was in the eighth month of her pregnancy. She appeared in good health. Both Bill and Rene seemed satisfied. They talked about Beth's death. They reported that Barbara mentioned Beth often and kept Bill and Rene answering her questions.

Rene visited Beth's grave regularly. Bill indicated that he went there even more often to keep the grave site clean. "I don't go there to get down on my knees and talk to her [Beth]. I just think it's a beautiful place," he said. Both reported that neither sets of grandparents had visited the grave. Both seemed disappointed about this fact. Rene said that her mother had stopped talking about the accident.

From the beginning of this call Bill had increased the rate of speed of talking. Rene discussed behavioural difficulties they were having with Barbara, such as her tendency to hide somewhere in the neighborhood and stay until she was found. Comparisons between her behaviour and Beth's were made, with Barbara's actions being cast in a less favourable light. Bill mentioned his regret at not spending more time with Barbara. He appeared agitated about this concern.

Since Beth's death, Bill had taken a course to train for another job. He indicated enthusiasm for his job and talked freely about its various aspects. His conversation

came rapidly and incessantly. This speed and continuous flow of speech was not typical of Bill's behaviour prior to Beth's death.

A pastoral call on Rene was made in the hospital on the occasion of the birth of their son. Rene seemed pleased at being a mother again. She reported that her boy was named after both sets of grandparents. This meant that he had an unusually long name.

The baptism of Barbara and John was attended by the parents, both sets of grandparents and various uncles and aunts. Everyone appeared to be in good spirits. No mention was made of Beth's death, now almost twelve months removed. Joking comments were made about Barbara's behaviour by her parents but they were not as pointed or sharp as they had been in the second period of bereavement (2-6 months).

The ninth and final interview with Rene and Bill occurred about thirteen months following the onset of bereavement. There seemed to be some uneasiness within their family as indicated by the disorganization of their usually neat and orderly house. Although the call had been previously arranged, the author got the impression that neither Bill nor Rene were prepared for it. The conversation focused on the baby, Barbara's behavioural problems, Bill's job and Beth's death.

Neither Bill nor Rene had enjoyed their recent holiday. They stated frankly that they were not happy

living in their present home although it was better than an apartment. They mentioned that Barbara had become more rebellious since Beth's death. Before she had been the quiet follower, accepting Beth's leadership. Since Beth's absence she had gradually become more self-assertive. She talked of running away. Her behaviour clearly was a puzzle to them. Rene used words such as "little terror" to describe Barbara. There seemed to be some connotations of anger in her descriptions.

Bill conversed freely about his work. He talked quickly and made comments in rapid-fire succession. Some of his stories involved the expression of anger toward his clients. One story, involving a high-speed chase with an impaired speeder ended in Bill expressing some delight in narrating his punishment of this driver. Rene chided Bill for his feelings and for behaving in this way. She was angry at Bill expressing anger through his job.

The interview ended with Bill commenting on Beth's death as "the accident." Words such as "killed," "death," "passed away," and "gone" were noticeably absent from the conversation. Both Bill and Rene appeared more relaxed at the end of this hour-long conversation than when it had begun.

Conclusions

For the sixth interview both Rene and Bill appeared in good spirits. They talked spontaneously about Beth's death and their visits to the cemetery. The fact that none

of the grandparents had visited the grave-site since the funeral seemed unusual. This fact, coupled with Mrs. W.'s discontinuance of any talk about the accident, might have suggested that she, at least, was avoiding the painful task of working through her own grief.

The increased rate of talking exhibited by Bill was noticeable. His body, whether moving or sitting, appeared taut and inflexible. This might have been a result of bereavement or could have resulted from tension springing from his new job.

Barbara's stubbornness and her tendency to get lost in order to be found perhaps indicated a reaction to her parents' anxieties. Since this occurred after Beth's death, it could be assumed that it constituted a reaction to Beth's loss or to changes in her parents' pattern of relating to her. Bill's announced regret at not spending enough time with Barbara might have signified a re-evaluation of his own functioning as a parent.

The birth of a son seemed to be a satisfying event for Rene. His unusually long name made up of the middle names of his maternal and paternal grandfathers suggested that Bill and Rene were perhaps trying to compensate their parents for losing a grandchild. At the baptism of Barbara and John, occurring in the twelfth month of bereavement, both sets of grandparents and Bill and Rene appeared normal. There was no talk of Beth's death. Joking comments about Barbara's behaviour were decidedly

not as numerous or as sharp as they had been in the 2-6 month period.

In the final interview there was less anger directed toward Barbara than had been the custom in the early stage of bereavement. Only one derogatory expression (little terror) was used by Rene. Her voice did not have the feeling overtones of irritation that it had had previously. Bill's delight in punishing an impaired client seemed to be a way of expressing the anger he felt toward the impaired driver whose negligence had taken Beth's life. Rene's reaction of extreme irritation to this story was probably significant, but almost impossible to interpret.

Bill's repeated reference to Beth's death as the accident, indicated the way in which he had conceptualized her absence. There was a definitive quality in his voice, as though he had worked it out for himself by saying, "It was an accident." There was no hint of a reference to life beyond the grave for Beth or any hope of meeting each other again. Rene seemed content to leave her interpretation of Beth's death in the same place. Since both had become much more relaxed and spontaneous by the end of an hour, they must have had a need to ventilate their thoughts and feelings.

CHAPTER IV

DOMINANT THEMES EVIDENT IN TWELVE MONTHS FOLLOWING BEREAVEMENT

Introduction

A number of dominant themes have been teased out of the summaries and conclusions of each of the four cases studied. The criteria used in qualifying the experience, the behaviour or the attitude of the bereaved as a dominant theme consisted of being reported or observed repeatedly in at least two of the four cases. The author has used as evidence also the records of other cases, which because of practical difficulties such as the intensely private nature of the grief experience and human mobility are incomplete. Where reference is made to evidence other than that recorded in the four cases of this study, the reference is to the "auxiliary cases." Of the other fourteen cases which have been observed and recorded, ten involved short preparation (one month or less) and four involved long preparation for the death. In the short preparation group were included four victims of suicide and one of murder. Ten cases involved the loss of a spouse and four the death of an offspring over the age of 16 years.

Dominant Themes in the Immediate
Reaction (1-30 days)

1. The immediate survivors were given to repeating the factual details of the death where the death was sudden and unexpected. This was not true where death (accidental or otherwise) involved violence or partial destruction of the body of the deceased such as in four of the auxiliary cases.

2. There was little overt evidence of grief in the immediate survivors. In two of the four cases the bereaved expressed fear that they were abnormal because they did not feel the acuteness of the loss at that point in time. Next-of-kin once removed, such as grandparents, expressed grief immediately and continuously. This appeared to be true in three of the four auxiliary cases which also allowed for the observation of grandparents.

3. The reality of the loss was not accepted immediately in any of the four cases. Setting a place at the table for the deceased or expecting him home by evening was common.

4. An attempt to find a purpose for the death by resorting to metaphysical causes (e.g., "His work was finished" or "She was too good to live" or "When your time's up, it's up") was true in three of the four cases.

5. There was an articulated appreciation for the support received from relatives, friends and associates during the period immediately following bereavement.

6. There was a considerable amount of anxiety resulting from the difficulties encountered in settling estates. This was especially true where the deceased was the family's only means of financial support.

7. Anger in the bereaved was reported or observed in two of the four cases. In both survivors it was directed toward other persons rather than to circumstances.

8. There appeared to be an increase in the rate of speech in two of the four cases. In one case this was accompanied by accelerated physical activity. Restlessness was noted in a third. In the ten auxiliary cases involving "short preparation" there seemed to be a sudden spurt of over-business.

9. A need to share their feelings and experiences was observed or articulated in all four cases. This was true in general for the fourteen auxiliary cases. However, it was not limited to the period immediately following the loss in cases where grief work had been delayed.

10. Some evaluation of the relationship of the survivor to the deceased was evident in three of the four cases. Positive elements in the relationship brought obvious satisfaction to the bereaved.

11. A cessation of customary routines occurred in three of the four cases. This appeared to be related to a sudden drop in the normal energy level of the bereaved and unexpected difficulty in making everyday decisions. Where grief-work was undoubtedly delayed, as for example,

in two auxiliary cases, interruption of customary routine did not occur immediately following the loss. Rather it was relegated to that time when grief-work was seriously undertaken.

. Dominant Themes in the Early
Reaction (2-6 months)

1. There was evidence to suggest that the bereaved attempted to compensate for their loss through identification with the deceased. Identification took such forms as unexpectedly claiming a personal possession used by the deceased, suddenly adopting an attitude which was formerly unique to the deceased, and taking over a function of the deceased. Replacement of the deceased through almost immediate re-marriage, pregnancy, and acquiring a similar type of relationship was evident as well.

2. Overt expression of grief occurred in three of the four cases, but took on different characteristics in each family. It varied from extended uncontrolled sobbing to quietly talking with tears in the eyes.

3. A more accurate perception of the reality of the loss and its implications for the future of the bereaved occurred in three of the four cases. For example, one widow contemplated the possibilities of living alone for the remainder of her life or of re-marrying. Another widow decided that her limited supply of time and energy prohibited her from performing the functions of a father

to her children.

4. Increasing awareness of discomfort in social settings was evident in three of the four cases (all three involving loss of a spouse). This occurred especially in settings which the couple had frequented together and/or situations where escorts were in vogue, e.g., a dance or banquet.

5. In two of the four families the bereaved reported receiving comfort not so much from relatives and close friends as from the example of others who had successfully survived similar circumstances.

6. The slowness and unexpected difficulty of settling an estate was cause of anxiety and frustration for two of the three widows (the third having been trained in legal affairs).

7. Anger was evident or reported in three of the four immediate survivors. It focused on such concerns as the disposition of items belonging to the deceased and the cause of the accident.

8. Disturbance of normal body functioning was reported or observed. Loss of weight was indicated in two of the four cases (as much as 30 pounds with one survivor). Inability to sleep was reported in three of the cases, in spite of a heavy work schedule.

9. Loneliness was reported by all three widows. Distinct from loneliness was a sense of being alone which was more acute during the time of day or week customarily

spent with the deceased, e.g., breakfast, bedtime and weekends.

10. A tendency to acclaim the virtues and achievements of the deceased was evident in two of the four cases. This was noticeable in the auxiliary cases too where death was preceded by a short preparation period.

11. A fear of not responding normally or being able to return to normality was expressed in two cases, both of whom lost their spouses by a sudden death. This was expressed in five of six auxiliary cases where loss of spouse followed a short preparation period.

Dominant Themes in the Late
Reaction (7-12 months)

1. It was evident in three of the four cases that there were attempts by the immediate relatives to compensate to other survivors for the loss of the deceased. For example, in one family certain functions of the deceased were adopted and performed. In another there was a reluctance to initiate functions at variance with those formerly performed by the deceased. In still another, a new-born infant was named after the maternal and paternal grandparents. This may have represented an attempt to replace a deceased grandchild.

2. In two of the four cases there developed self-awareness relative to the process through which they were passing. Ability to compare the present with past grief experiences was evident. Rational and irrational

components in their cognitive life were recognized.

3. Overt expression of grief through crying seemed to be replaced by a generalized feeling of emptiness which appeared to consist of such specifics as a sense of absence of the deceased, of a loss of functions formerly performed by the deceased, and of a loss of human contact and opportunity previously provided by the vocational or recreational habits of the deceased.

4. Continuing difficulty in mixed social settings was reported in three of the four cases. This was evident in four of the auxiliary cases which involved loss of a spouse.

5. It was reported in two of the four, and observed in a third survivor, that belief in a deity and life after death was a source of strength toward surviving the experience of grief.

6. Although concern over estate settlement played an important part in the life of two of the four cases at the six-month point, it almost totally diminished by the twelfth month.

7. The emotion of anger, evident in three of the four cases, lessened in intensity toward the end of this period. An exception to this trend concerned a survivor who previously had shown little or no sign of grief, but began expressing hostility toward others via his vocational role.

8. A decrease in the rate of speech and rapidity of

physical movement seemed evident in the survivors affected.

9. The intensity of the sense of aloneness at those times customarily shared with the deceased decreased.

10. A less idealized image of the deceased and his virtues and achievements emerged in two of the four cases. Evident was a willingness to examine and express negative results of the deceased's behaviour. This was not apparent in any of the auxiliary cases involving the loss of offspring.

11. The ability to make decisions and to actualize them was evident in two of the four cases in which this capacity had been suspended. The suspension of and regaining of this capacity was evident in six of the auxiliary cases involving a loss of spouse preceded by a short preparation period.

12. By the end of the twelfth month no further physiological disturbance (e.g., loss of appetite, inability to sleep) was reported or observed.

13. There appeared to be a return of energy and self-confidence toward the end of this period in two of the four cases which had been affected in this respect.

CHAPTER V

A PROFILE OF GRIEF REACTION IN THE FIRST YEAR OF BEREAVEMENT AND ITS RELATION TO THE LITERATURE

Introduction

Utilizing as a basis the dominant themes in the experience of the survivors during the first year of bereavement, it is possible to attempt a reconstruction of the grief process for this period of time. The author will relate the reconstruction to the published and reliable unpublished literature. In order to develop a model for understanding the process, it might be helpful to see the periods of immediate, early, and late reaction in terms of "adjustment to shock," "recognition of loss," and "compensation for loss" respectively.

Adjustment to Shock

This is a period of orientation and it spans the first month or so of bereavement. The survivor repeats the details of the occasion of the death to many people. There is often little evidence of the "traditional" symptoms of grief, e.g., tears. Rogers (1963) theorized that grief was closely tied to goals and values so that as soon as the meaning of the situation was clarified to the survivor, the emotional reaction to it would manifest

itself as well. Lindemann (1944) found that grief could be delayed for several weeks or longer. Oates (1954) noted that the survivor's life continued automatically until the shocking truth of death was able to enter the subjective realm of the survivor. Hodge (1972), contrary to the above, found that emotional release usually took place before the funeral.

There appears to be little or no acceptance of the reality of the loss on the part of immediate survivors. Lipson (1969) supported this finding, theorizing that the ego stalled the recognition of a painful reality which it was helpless to alter. Fenichel (cited in Lipson, 1969) found that "grief is obviously a postponed and apportioned neutralization of a wild and self-destructive kind of affect which can still be observed in a child's panic upon the disappearance of his mother" (pp. 268-275). Parkes (1973) found that 63% of widows and widowers in the "s.p." group reported an immediate reaction of disbelief (see Table 4, Appendix A).

Where the death is unexpected there seems to be an attempt by the survivor to find a purpose in its occurrence. This phenomenon is not recorded in the available literature. Perhaps it is a direct result of the minister-parishioner relationship and the religious context out of which it is born. In other words, ministers are expected to know "why" things happen. Scientists are expected to know "how" they happen. At this time in bereavement the survivor

appears to gain his "support" from relatives and friends. Their presence may account for the full impact of the loss being lessened in its effect. Spiro (cited in Volkart & Michael, 1957) concurred with this in reference to his study of the Ifaluk people.

Typical of this period is anxiety. Where the deceased has been the family's sole means of financial support, the anxiety might focus on estate settlement. Freud (1917/1949) referred to anxiety in terms of the struggle which occurred at the time of death because the ego never willingly abandoned a libido position. The testing of reality has proved that the loved object no longer exists and requires that all libido be withdrawn from its attachments to the object. There is an increase in the rate of speech and a general restlessness. Lindemann (1944) found that over-activity was typical in cases where the bereaved had not yet experienced his grief.

While there is some evaluation of the relationship to the deceased, it is the positive elements which are verbalized at this point in time and bring obvious satisfaction to the mourner. Freud referred to a tendency for survivors to belittle themselves and thus make a moral judgment of themselves. Thus the constructive aspects of a relationship might tend to be a source of good feeling at this time.

Low energy, inability to make decisions and a suspension of customary routine often occurs. Lindemann

found a loss of strength amongst the bereaved. Freud referred to the inhibition of all activity and the loss of interest in the outside world to be the result of "exclusive devotion to mourning which leaves nothing over for other purposes" (p. 153). Lipson (1969) contended that the withdrawal of the libido took place bit by bit, requiring a large amount of time and energy.

In "normal" grief there does not appear to be a loss of self-esteem. This was Freud's conclusion as well. However, unlike Freud, this author found no evidence of the loss of capacity to love in cases of "normal grief."

Thus the grief process begins with a period of orientation. It is a time of adjusting to shock, a period of preparation for assimilation of the impact and meaning of the death to the survivor.

Recognizing the Loss

The phase of orientation is followed by a time in which the survivor struggles to recognize the reality of the loss. This seems to reach its maximum acuteness in the first six months of bereavement. The mourner attempts to compensate for his loss by identifying with some aspect of the deceased's personality or some particular property of the loved one. Janis (1969) noticed in children the two compensatory mechanisms of unconscious identification and postponed obedience. In the first, the child endeavored to retain the parent symbolically by adopting a mannerism of his deceased parent. In the second, he

suddenly accepted a value, attitude, or ideal which he had hitherto rejected.

Although the timing and intensity of crying appears to be dependent on personality factors, length of preparation for bereavement and nature of the loss, there appears to be a several week delay before tears flow easily. Even then expression varies from convulsive sobbing to tearful appearance. Clayton (cited in Kutschner, 1969) found that crying had occurred in only 50% of the survivors up to twenty-two days following the death. Freud (1917/1949) theorized that the mourner knew who he had lost but not what he had lost. The latter came to his consciousness through the passage of time as he discovered the absence of certain functions. There is evidence that a beginning is being made in accepting the death and its implications. Freud considered that a period of time was necessary for the ego to test reality and to free its "libido from the lost object" (p. 163).

During this time there develops a discomfort in social settings--especially in the case of widows and widowers. This might be explained partially by Freud's theory that the mourner gives up the loved object one memory at a time and that each confrontation with the reality of the loss is painful. Rogers (1963) considered that the deceased had become a part of the dream system as well as the affect system of the mourner. Circumstances which the couple had shared would remind the survivor that not only were past

activities irretrievable, but future hopes were diminished. Lindemann (1944) noted a severe change in patterns of social interaction in the period between the death and experiencing grief.

Loss of appetite and inability to sleep are common symptoms at this time. Freud reported "sleeplessness and refusal of nourishment" (p. 156). Lindemann found changes in the digestive system. Parkes (1973) cited problems with sleeplessness in one-third of the mourners during the first year of bereavement (see Table 1, Appendix A). These symptoms might be explained by Freud's theory that the inner labour of mourning required energy, involved struggle and sometimes was accompanied by a belittling process by which the survivor made moral accusations of himself relative to his relationship to the deceased.

Where the loss of a spouse occurs a generalized feeling of loneliness and a sense of aloneness appears to develop. Parkes found intense feelings of loneliness amongst widows and widowers during the first year of bereavement (see Table 6, Appendix A). Lindemann found that mourners were surprized at the extent to which they previously shared activities with the deceased. These had ceased to hold the same significance. A tendency to acclaim and idealize the past virtues and achievements of the dead appears to be typical in "s.p." cases. This might be an attempt to avoid the feelings of guilt which researchers such as Lindemann found amongst survivors.

Typical of this phase of grieving over a dead spouse is a fear of not being able to regain "normality." Hodge (1972) noticed this symptom amongst his patients. While 72% of the family practitioners surveyed thought that bereaved patients functioned normally by the end of 3 months, 74% considered that it took longer for them to feel "normal." Six percent suggested a period of up to 24 months before normality was regained (see Appendix B).

Compensating for the Loss

Grief symptoms reflecting the death of the deceased and the loss of functions performed by the deceased appear to reach their greatest intensity in the first six months. The next several months find the mourner endeavoring to compensate for the death of the family member. For example, other persons might be selected as recipients of affection or sometimes functions formerly maintained by the loved one are carried on by the survivor. Freud (1917/1949) thought that the mourner transferred his love to another object at a later phase of the grief process, the first stages of grief being devoted entirely to mourning. At this point in time the mourner develops an awareness of the nature of the experience through which he is passing. He can often see the rational and the irrational components in his own behaviour. Lipson (1969) explained this phenomena by referring to ego-splitting in the mourner which was not related to a special type of reaction but a part of the "normal" mourning process.

By this time crying and tearfulness have developed into a generalized feeling of loss. This is triggered and nourished by a continuing sense of absence of the deceased and missing specific functions, opportunities and activities formerly initiated by or shared with the loved one. There is continuing difficulty in participating in mixed social functions in cases of widows and widowers. Westberg (1961) mentioned the unwillingness of the bereaved to participate in usual patterns of conduct. He conjectured that this might be their way of reminding others of the loss or protesting the indifference of those who take up life again and for whom the death will make little difference. Parkes (1973) found that 44% of widows and widowers in "s.p." cases would not consider dating as long as two or four years following bereavement (see Table 6, Appendix A).

Amongst some mourners a belief in God and an after life becomes a source of strength at this time, replacing the support and example of others which appeared to provide comfort during the earlier stages of mourning. Although little or no support for this contention is found in the published literature, 17% of the family practitioners reported that they referred bereaved patients to religious resources in the community (see Appendix B). Henceforth, anxiety which focused on settlement of the deceased's estate diminishes. However, Parkes (1973) found that an over-all anxiety was common to "s.p." cases two to four

years following bereavement (see Table 6, Appendix A).

Anger, common in survivors of "s.p." cases is often expressed to people near to the mourner. Westberg (1961) reported anger directed to the nurse, doctor, and clergyman of a deceased patient. Hodge (1972) recorded that hostility and projection toward other persons usually occurred in the first 12 weeks of bereavement. Anger toward physicians was mentioned by only two family practitioners (see Appendix B). Lindemann (1944) mentioned finding that the bereaved became strongly dependent upon anyone who stimulated them to activity and angry toward those who refused to cooperate in this way.

By the twelfth month the rate of speech has returned to normal. There is a willingness to recognize some negative aspects of the deceased's life and behaviour. At the same time an ability to make decisions and to actualize them returns. The ability to sleep and the appetite for food returns.

Energy and self-confidence is usually restored by the twelfth month. The ego is no longer devoting itself exclusively to mourning and therefore it has energy left over for other things. Lipson (1969), reflecting Freudian theory, concurred. He thought that a slow return of energy and a gradual loss of sadness was the result of partial detachments by the ego from the introjected loved object. Jackson (1959) theorized that the later stages of the grief process found the mourner re-investing himself

in other productive relationships. Hodge indicated that re-adjustment might require up to 24 months. Parkes (1973) found that a return to "normal" had not occurred in some "s.p." cases by the end of four years (see Table 6, Appendix A).

Summary and Conclusion

Based on the results of this study, the person who works to help the bereaved can expect the grief process to follow certain trends. However, the reader should be aware that this study did not produce sufficient data to assume that the experience of the bereaved is universal, whether they are a husband, wife, parent or child. The findings of this study apply only to the experience of a surviving wife. The grief experience of the widower may or may not be similar.

In the beginning the survivor may show little evidence of loss. Inability to adjust his behavioural, cognitive, and affective life to the new reality will be common. Dependency upon friends and relatives to decide on and execute necessary daily routines is to be expected.

After the initial shock a gradual realization of the loss will develop, attended by tearful upsets which will vary according to the nature of the deceased, the personality of the survivor and the attending circumstances. Disturbance of normal patterns of eating, sleeping, emotionality and sociability will occur frequently. An increase in the activity level of the mourner may happen.

Grief symptoms will probably reach their most intense expression in the first six months following the loss.

By the second half of the first year the intensity of the symptoms will tend to subside. The mourner will begin to realistically adjust to life without the loved one. He will try to compensate for the deceased's absence. A return to "normal" behaviour can be expected by the end of the twelfth month. However, internally the effects of the loss may still be a cause of disturbance to the survivor.

The above summary refers to the pattern of "normal" grief. Differences in the nature of the deceased, the survivor, their relationship, the economic circumstances and the preparedness for the loss will determine the pattern. In cases of sudden death and ambivalent relationships the process may be delayed and the grief develop pathological elements.

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APPENDIX A

Table 1
Scale for the Prediction of Outcome
After Bereavement

Predictive Variables	Vector	Eta	P
Coder's Prediction of Outcome	0.42	0.49	0.0004
Yearning (3-4 weeks after bereavement)	0.41	0.46	0.001
Attitude to Own Death	0.04	0.45	0.0015
Duration of Terminal Illness	0.16	0.44	0.0016
Social Economic Status	0.19	0.30	0.034
Anger (3-4 weeks after loss)	0.44	0.20	0.071
Self-reproach (3-4 weeks after loss)	0.32	0.25	0.074

Note. From Unexpected and untimely bereavement: a statistical study of young Boston widows and widowers by C. M. Parkes. Unpublished manuscript, Tavistock Institute of Human Relations, London, 1973.

Table 2

Correlations between Mode of Death and 'Combined
Outcome' Score 13 months after bereavement

	r	p
Cause of Death <u>not</u> cancer	0.27	< 0.05
Short Duration of Terminal Illness	0.29	< 0.05
Respondent not present at death	0.17	N.S.
Preceding death survivor and partner discussed eventuality of death realistically (plans, wishes, etc.)	-0.16	N.S.
Survivor says he deliberately avoided talk of possibility of death with partner	-0.10	N.S.
No opportunity to discuss death with partner	0.25	0.05

Note. From Unexpected and untimely bereavement: a
statistical study of young Boston widows and widowers by
C. M. Parkes. Unpublished manuscript, Tavistock Institute
of Human Relations, London, 1973.

Table 3

Some Indices of 'Outcome' 2-4 years after bereavement
in Short and Long Preparation

	Short Preparation Group		Long Preparation Group		p
n	18		41		
Coder's Overall Outcome					
Good or Very Good	1	(6%)	26	(63%)	<.001
Combined Outcome Score					
<19	3	(17%)	15	(37%)	<.05
Remarried	1	(6%)	11	(26%)	.07*
Problems some concern-					
Role Functioning	13	(72%)	14	(34%)	<.02
Financial Affairs	14	(81%)	12	(29%)	<.01
Coder's Assessments:					
Acceptance good or very good	9	(50%)	35	(85%)	<.05
Attitude to the future					
good or very good	5	(28%)	28	(68%)	<.01

*One-tailed Chi-Squared test.

Note. From Unexpected and untimely bereavement: a
statistical study of young Boston widows and widowers by
C. M. Parkes. Unpublished manuscript, Tavistock Institute
of Human Relations, London, 1973.

Table 4

Early Reaction at 3-4 weeks after Bereavement
x Length of Preparation

	Short Preparation Group		Long Preparation Group		p
n	24		46		
Immediate Reaction of Disbelief	15	(63%)	11	(24%)	2.01
Overall Anxiety at interview moderate to severe	10	(43%)	8	(18%)	<.05
Overall Affective Upset at interview moderate to severe	10	(43%)	9	(20%)	<.05
Emotional Disturbance Score >10	14	(67%)	10	(14%)	<.01
Self-reproach at interview (Some)	16	(69%)	17	(37%)	<.05
Coder asserts R. would welcome own death or doesn't care	11	(46%)	7	(16%)	2.02
Respondent agrees: "I wouldn't care if I died tomorrow"	7	(30%)	3	(7%)	<.05
"How could he/she leave me?"	7	(33%) *	3	(7%)	<.02

*Percentage corrected for missing data.

Note. From Unexpected and untimely bereavement: a statistical study of young Boston widows and widowers by C. M. Parkes. Unpublished manuscript, Tavistock Institute of Human Relations, London, 1973.

Table 5

Later Reaction 6-8 weeks after Bereavement

x Length of Preparation

	Short Preparation Group		Long Preparation Group		p
n	24		46		
Overall Anxiety at Interview Moderate to Severe	13	(54%)	13	((28%)	<.05**
Coder asserts would welcome own death or doesn't care	10	(52%) *	9	(18%)	<.05**
Respondent agrees: "I don't seem to laugh any more"	8	(42%) *	32	(70%)	<.05
Has visited grave by 6-8 weeks interview	10	(43%)	32	(70%)	<.05
Initiates and accepts more invitations to be with others	9	(38%)	30	(65%)	<.05
Coder predicts good outcome	14	(59%)	39	(85%)	<.05

*Percentage corrected for missing data.

**One-tailed chi-squared test. All others are two-tailed.

Note. From Unexpected and untimely bereavement: a
statistical study of young Boston widows and widowers by
 C. M. Parkes. Unpublished manuscript, Tavistock Institute
 of Human Relations, London, 1973.

Table 6

Features at Follow-up 2-4 years after Bereavement
x Length of Preparation

	Short Preparation Group		Long Preparation Group		p
n	18		41		
Sense of Presence of the Dead Person (occasional to always)	11	61%	8	19%	<.01
Feels: "I try to behave as he/she would want me to"	15	(83%)	18	(44%)	<.02
Feels: "As if I could have done something to prevent his/her death	8	(44%)	6	(15%)	<.05
Feels: "I still ask myself why it happened"	11	(61%)	12	(29%)	<.05
Feels: "It's not real; I'll wake up and it won't be true"	8	(44%)	6	(15%)	<.05
Feels: "Down deep I wouldn't care if I died tomorrow"	8	(44%)	6	(15%)	<.05
Loneliness (often to always)	8	(44%)	6	(15%)	<.05
Overall Anxiety (moderate to severe)	13	(72%)	13	(32%)	<.02
Socializing (Fair to Poor)	9	(50%)	8	(19%)	<.05
Will not yet consider dating	8	(44%)	4	(10%)	<.01

Note. From Unexpected and untimely bereavement: a statistical study of young Boston widows and widowers by C. M. Parkes. Unpublished manuscript, Tavistock Institute of Human Relations, London, 1973.

APPENDIX B

Table 7

Family Practitioners' Assessment of the Needs
of the Bereaved Patient

I. Approximately what number of patients come to you over a one-year period for reasons of bereavement?

	<u>Check one</u>
1-10	<u>61%</u>
11-20	<u>21%</u>
21-30	<u>10%</u>
31-40	<u>3%</u>
Other responses	<u>5%</u>

II. How many visits would the "average" patient make for reasons related to bereavement in the first year following a death?

	<u>Check one</u>
1-2	<u>42%</u>
3-5	<u>48%</u>
6-8	<u>3%</u>
Over 8	<u>3%</u>
Other responses	<u>4%</u>

III. Have you noticed a tendency for the surviving members of a family to become ill at the time of bereavement?

Check "Yes"	<u>42%</u>
or	
"No"	<u>52%</u>
Other responses	<u>6%</u>

IV. If your answer to the above question is "Yes," which of the disorders below would fall into the category of common complaints?

	<u>Check one or more</u>
Upper Respiratory System	<u>6%</u>
Gastro-intestinal System	<u>19%</u>
Central Nervous System	<u>19%</u>
Psychological	<u>53%</u>
Other (Please specify)	<u>3%</u>

V. In general, treatment mostly consists of:

	<u>Check one or more</u>
- listening to the patient	<u>33%</u>
- giving the patient information	<u>18%</u>
- administering medication	<u>18%</u>
- explaining the nature of the grief process	<u>23%</u>
- encouraging the patient to make use of the religious resources of the community	<u>18%</u>
Other response	<u>1%</u>

VI. In your opinion, is it best for the survivor(s) to experience the acuteness (realization, agony, devastation) of the loss:

	<u>Check one or more</u>
- at the time of death	<u>89%</u>
- 1 month following death	<u>8%</u>
- 2 or 3 months following death	<u>..</u>
- 6 months following death	<u>..</u>
- 12 months following death	<u>..</u>
- Not at all	<u>..</u>
- Other responses	<u>3%</u>

VII. In general, what length of time is needed before the "average" bereaved is able to function "normally" again?

	<u>Check one or more</u>
1-3 months	<u>72%</u>
4-6 months	<u>19%</u>
7-12 months	<u>6%</u>
13-24 months	<u>3%</u>
Longer than 24 months	<u>..</u>

VIII. In general, what length of time is needed for the "average" bereaved person to feel "normal" again (to have completed their "grief work")?

	<u>Check one or more</u>
1-3 months	<u>25%</u>
4-6 months	<u>28%</u>
7-12 months	<u>31%</u>
13-24 months	<u>9%</u>
Longer than 24 months	<u>7%</u>

IX. Briefly, what is the best use of anxiety reducing medication (such as tranquilizers) in the treatment of the bereaved?

To induce sleep - 33%

To keep person functioning - 9%

At time of funeral - 9%

Sparingly - 3%

Short-term - 6%

Never - 19%

Other responses - 22%

X. Do you think the taking of medication lengthens the course of the "normal" grief process for the bereaved?

Positive response - 40%

Negative response - 53%

Other response - 6%

XI. Any other comment?

- Each case differs significantly.
- Hostility and guilt in survivors are destructive to doctor-patient relationship.
- Children recover quickly from loss.
- Survivors without religious beliefs have greatest difficulty coping.
- Grief symptoms sometimes emerge months following the loss.

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